

VA MENTAL HEALTH PROGRAMS

Y 4. V 64/4: S. Hrg. 103-314

VA Mental Health Programs, S. Hrg....

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

AUGUST 3, 1993

Printed for the use of the Committee on Veterans' Affairs



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VA MENTAL HEALTH PROGRAMS

TUESDAY, AUGUST 3, 1993

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 11:05 a.m., in room SR-418, Russell Senate Office Building, Hon. John D. Rockefeller IV (Chairman of the Committee) presiding.

Present: Senators Rockefeller, Akaka, and Simpson.

OPENING STATEMENT OF CHAIRMAN ROCKEFELLER

Chairman ROCKEFELLER. Good morning, everyone. I want to apologize again. For those who don't know, we just had four or five consecutive votes, which caused us to be late, one of which, of course, was for Ruth Bader Ginsberg, and others. So I apologize, particularly to those who have come from out of town.

There are a lot of our veterans who continue to carry the burden of post-traumatic stress disorder and other mental illnesses; one could characterize them as our forgotten veterans. These are warriors who have not participated in welcoming ceremonies at home. Rather, they are our brothers and sisters who have come home to lives that are broken and fragmented. Today's hearing will focus on what the VA does to meet the mental health needs of these forgotten heroes and what we can do to make these efforts more effective.

At this very moment, there are more than 5,000 mentally ill veterans who have been in VA hospitals for more than 1 year; more than 30,000 who have been hospitalized for more than 45 days within the past 2 years; and more than one-half million who have been hospitalized for shorter periods of time or treated as outpatients. They need and deserve our help to get good treatment that will minimize their problems and enable them to lead as productive lives as possible.

These veterans often lack the power to press for the services they need. There is no massive lobbying effort on their behalf; indeed, among those who work for health across our country, whether it be in the Department of Veterans Affairs or in our national health care reform process, mental health is often brushed aside. They are wrong. While there are some very dedicated professionals and family members and friends who have worked hard to help these veterans, individual efforts on their own don't do enough. All too often our Nation, in my judgment, has failed to address their complex needs and provide the comprehensive services that they require

and, indeed, that they have earned. VA can and must take a leadership role in all of this.

It is endlessly important for people to understand that the Department of Veterans Affairs is the largest provider of mental health services in the United States of America. As such, it provides a perfect setting for large-scale, multisite research studies that can yield significant and valid results that will help people. This has enormous implications for the entire Nation. However, while more than 40 percent of VA patients suffer with some degree of mental illness, less than 12 percent of VA's research budget goes to improving VA mental health services. More funds must be devoted to mental health research to remedy this clear imbalance.

As the veterans' population ages, older veterans constitute an increasing proportion of the mentally ill veterans. VA has an opportunity here to become a leader in geriatric psychiatry, but to date, VA officials have done little to foster and encourage research and clinical care in this area. By missing the opportunity to actively engage in research, VA is also shirking its duty to its veterans' population.

Today we will examine two proposed bills. One would create so-called centers of excellence for mental health research. The goal of these centers would be to increase the basic knowledge of mental illness and improve the quality of care for the mentally ill.

The second bill we will review, S. 1226, is legislation introduced by my good friend, Senator Akaka, who will be here shortly. His legislation is a very thoughtful attempt to improve the services offered to veterans through the Department's Readjustment Counseling Service, more commonly known as Vet Centers. I know that Senator Akaka has spent a lot of time working on this legislation, and I intend for the Committee to act on his legislation, hopefully very soon.

Our witnesses include Deputy Secretary of Veterans Affairs, Hershel Gober—we are honored by that—and other VA officials, VA mental health professionals, and representatives of veterans' service organizations and other organizations concerned about VA mental health services. I'm very pleased that they are all with us today.

I was going to yield to other Senators for comments, but that would be awkward. [Laughter.]

Originally, we had hoped to have Representative Marcy Kaptur from Ohio with us here this morning, but she was not able to attend. However, because she cares about this subject, we will make her written statement a matter of the record.

[The prepared statement of Ms. Kaptur appears on p. 82.]

Chairman ROCKEFELLER. Now, we have an extraordinary first panel. We have an extraordinary second panel, too, Hershel, but the first panel is great. It consists of VA medical center personnel and representatives from two associations. We have Dr. Dennis Charney, Chief of the National Schizophrenia Biological Research Center at West Haven VA Medical Center; Dr. Matt Friedman, Executive Director of the National Center for PTSD, White River Junction, Vermont—that is called coming some distance; Dr. John Lipkin, Chief of Staff at the Perry Point VA Medical Center, representing the American Psychiatric Association; Dr. Chuck O'Brien,

Director of Psychiatric Services, Philadelphia VA Medical Center; Dr. Pat Sutker, Chief Psychologist, PTSD Clinical Team, New Orleans VA Medical Center—that's called distance; and Dick Greer, Director, National Alliance for the Mentally Ill.

Let me remind each of our witness that we have your written statements, that they are part of the record, and that I am going to limit your oral remarks to 5 minutes. Some of you will be accustomed to this and some of you will not. If you're not, it's difficult, but please adjust to it, because I will abide by it.

Dr. Charney, maybe we can begin with you, sir.

STATEMENT OF DR. DENNIS CHARNEY, CHIEF OF PSYCHIATRY, WEST HAVEN VA MEDICAL CENTER, AND PROFESSOR OF PSYCHIATRY AND ASSOCIATE CHAIRMAN FOR RESEARCH IN PSYCHIATRY, YALE UNIVERSITY SCHOOL OF MEDICINE

Dr. CHARNEY. Thank you very much. Currently, I am Chief of Psychiatry at the VA Medical Center in West Haven, Connecticut. I'm also Professor of Psychiatry and Associate Chairman for Research in Psychiatry at the Yale University School of Medicine.

The psychiatry service which I direct at West Haven is a large and complex one, and, in fact, it raises many of the issues that you've begun to address here today. We have 188 psychiatric inpatient beds, outpatient clinics with a workload of over 60,000 visits per year, and specialized treatment programs for patients with schizophrenia, post-traumatic stress disorder, depression, and substance abuse. Further, we have been developing a variety of psychiatric rehabilitation programs designed to help patients with chronic mental illness obtain adequate housing and return to productive vocational pursuits.

The Psychiatric Research Program at our VA is among the largest in the VA health care system. For example, we are the site for the Clinical Neuroscience Division of the National Center for Post-Traumatic Stress Disorder, of which Dr. Friedman is the overall director. We have one of the two VA-funded Alcohol Biological Research Centers and one of the three VA-funded Schizophrenia Biological Research Centers. In addition, we house the principal site for a VA-funded 15-hospital, multicenter study designed to determine the long-term efficacy of a new antipsychotic drug called Clozapene.

Most of the psychiatrists at our medical center are not only expert clinicians dedicated to care of the veterans, but are also VA, NIMH, NIDA, and IAAA-funded investigators committed to the discovery of new and improved treatments for our patients. In fact, it's this characteristic of applied research that in many ways distinguishes the research at VA medical centers. That is, the research is designed to improve treatment rather directly.

The psychiatrists and psychologists at our medical center are also, in general, full-time faculty members at the Yale University School of Medicine and, as such, are devoted to the education of Yale medical students and psychiatric residents. Thus, in view of my own personal clinical care research and educational responsibilities in the VA health care system, I appreciate the opportunity to discuss with the Committee issues related to VA clinical programs

for the chronically mentally ill, VA-funded psychiatric research initiatives, and the importance of maintaining strong and mutually beneficial medical school affiliations.

Thank you very much.

[The prepared statement of Dr. Charney appears on p. 84.]

Chairman ROCKEFELLER. Thank you, sir, very much.

Dr. Friedman, you've already been referred to by the first witness. We welcome your testimony, sir.

STATEMENT OF DR. MATTHEW J. FRIEDMAN, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER, WHITE RIVER JUNCTION, VERMONT

Dr. FRIEDMAN. Thank you very much. My name is Matt Friedman. I am the Executive Director of the National Center for Post-Traumatic Stress Disorder, and Professor of Psychiatry and Pharmacology at Dartmouth Medical School.

The National Center for PTSD was mandated by the U.S. Congress in 1984, and the current National Center has been in existence almost 4 years. During that period of time, we have established ourselves, I think, as a world leader in research on the psychological, psychophysiological, and neurobiological aspects of PTSD. Our research, as Dr. Charney mentioned, who heads one of our seven divisions, includes development of clinically relevant research concerns, such as developing diagnostic assessment tools, identifying biological markers, and testing different kinds of treatments.

Although we have a core recurring budget that supports many of our staff members, we depend very much on outside research funding, both VA and NIMH as well as private foundations, to carry out the activities in which we have been engaged. I have furnished the Committee with our annual reports, so you have a complete list of the many research activities in which we have been engaged, as well as a short list included in my previously submitted written testimony.

In addition to research, the National Center is responsible for providing education and support for the many VA PTSD programs, both hospital-based and Vet Center programs. In that regard, we have carried out a variety of educational and training activities, including publications in journals, making formal presentations, providing on-site clinical training, providing consultation, mini-residencies, teleconferences, et cetera.

In addition, one of the problems in the National Center is trying to get the word out to the field, and we have two newsletters that partly do that. We have a clinical newsletter with a circulation of 6,000 to VA and non-VA clinicians and we have the PTSD Research Quarterly, which is distributed to 5,000 scholars and PTSD researchers throughout the world.

What's been very interesting in the 4 years of running the National Center is that when you run a national center, you have to be responsive to the national needs, so our own agenda has frequently been interrupted by major events, such as Operation Desert Storm, in which we collaborated closely with the Department of Defense, and a variety of natural disasters, such as the Loma Prieta earthquake and the three hurricanes, Andrew, Iniki,

and Hugo. We also worked with the State Department during the Iraq-Kuwait hostage crisis.

One of the goals, I think, of the National Center is to make ourselves more available to different Government agencies, because, after all, we are the only National Center for PTSD within the country, and one of my activities currently is to see if we can work more closely and develop better collaborative relationships with different agencies and cabinet-level departments.

One of the problems with the National Center, as I see it, is that as VA resources for treating PTSD increase in terms of at least special funding, our responsibilities to provide the guidance both for educational programs and to support research—not just at the National Center, but throughout the VA system—have increased as well.

In the future also, I would hope that the National Center can play a role in the development of the national health care system, because, after all, as we've learned, trauma is not just something that happens to veterans. Although that is our first responsibility, trauma is something that happens in other contexts such as domestic violence. We're learning that people who were previously traumatized as children are more vulnerable to developing PTSD during military life. Trauma is something that happens to natural disaster survivors, et cetera. I think that the National Center has something to offer, and we hope that we can discuss mechanisms and a variety of options through which all Americans can have their trauma-related problems addressed programmatically through a national health care system.

Finally, in view of the major thrust of the hearing today, I'd like to emphasize something that hasn't been emphasized, and that is that PTSD is a chronic mental illness. Many people with PTSD do not get better and many of them go on to have a career as a chronic mental patient, which is very similar to some of the schizophrenic patients that we'll be talking about later. So I think as we're talking about chronic mental illness and we're talking about the mental health problems of the homeless veterans, I think one needs to keep in mind that these are not just schizophrenic patients. Many of them are PTSD patients who have been overlooked or have perhaps been misdiagnosed.

Thank you.

[The prepared statement of Dr. Friedman appears on p. 84.]

Chairman ROCKEFELLER. Thank you, sir, very, very much.

Now we will hear from Dr. Lipkin, representing the American Psychiatric Association.

STATEMENT OF DR. JOHN O. LIPKIN, CLINICAL PROFESSOR OF PSYCHIATRY, UNIVERSITY OF MARYLAND, AND CHIEF OF STAFF, PERRY POINT VA MEDICAL CENTER, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. LIPKIN. Good morning, Mr. Chairman. I'm John Lipkin, Clinical Professor of Psychiatry at the University of Maryland, Chief of Staff at the Perry Point VA Medical Center, and a member of the American Psychiatric Association's Committee on Veterans Affairs. I appear before you today on behalf of the American Psychiatric As-

sociation, a medical specialty society representing more than 38,000 psychiatric physicians nationally.

I've been actively involved in the acute and long-term care of people with psychiatric illness since 1970, when I began 2 years at the Bethesda Naval Hospital. I've worked at the Portland, Oregon VA Medical Center, in the central office of the VA, and currently as the Chief of Staff at the Perry Point VAMC.

I'm pleased, on behalf of the APA, to testify in support of both your legislation concerning the development of MIRECCs—Mental Illness Research, Education, and Clinical Centers—and Senator Akaka's bill on the Readjustment Counseling Service amendments.

I wanted to talk briefly about some things that are contained in my testimony, because I don't think I can read you my testimony in 4 minutes. I think it's important to recall that the VA has reflected the mainstream of American medical practice, by which I mean that the stigma which is a social phenomenon for mental illness is also part of the medical community's attitudes toward mental illness.

I think if you look at recent current events in this city—the death of Chairman Wilson on the D.C. City Council, the death of Mr. Foster, counsel to the President, people with major depressive disorders whose illnesses were either barely understood or kept secret—you have to speculate that they did not receive the same quality of medical care and attention and support from their colleagues that Reggie Lewis of the Boston Celtics who died of a heart problem received from his friends. Mr. Lewis was a victim of medical uncertainty, which can happen to any of us. I think Mr. Foster and Chairman Wilson may have been the victims either of the poor coverage of mental health, which today's Washington Post details substantially, and/or of the general stigma attached to mental illness.

During my 20 years in the VA, I have to say that I've watched the reduction of services overall to psychiatric patients occur in ways that I found both frustrating and difficult to understand. Part of that is because the medical community believes that if somebody acts strangely and does socially unacceptable things, they must be a psychiatric patient, at least until such time as we discover the cause of their behavior and the treatment for it. For example, some vitamin deficiency syndromes and syphilis were conditions which caused strange behavior and which were treated by psychiatrists until we found that vitamins cured the vitamin deficiency or that penicillin was a pretty good treatment for syphilis. Then other people took over.

What's happened in the VA and, I think, in the medical community at large is that given a choice between high-tech, high-glamour procedures, such as coronary artery surgery, versus additional treatment for major depression—bipolar disorder—the choice is almost invariably made, whether it's at medical schools in the curriculum time, at VA hospitals in the development of new facilities, or in the VA research budget, to put the money where the glamour is, even though NIMH data would suggest that the treatment of manic-depressive disorder—bipolar disorder—is about 80 percent effective and the treatment of coronary artery disease with angioplasty is about 40 percent effective.

The other thing I think is pertinent is that just as the private health community undercovers mental illness, so, I believe, the VA has undercovered mental illness in our budgeting process. I think the numbers are approximately that 40 percent of VA patients are in VA care because of mental illness, but they receive something less than 20 percent of the VA budget. That doesn't make any sense to me. The research data is equally out of whack.

So I would, on behalf of the APA, welcome the development of MIRECCs as a way to improve the research balance and welcome your efforts on behalf of psychiatric patients across the system, both in the VA and outside.

Thank you very much.

[The prepared statement of Dr. Lipkin appears on p. 85.]

Chairman ROCKEFELLER. Thank you, Dr. Lipkin.

Dr. Sutker.

**STATEMENT OF DR. PATRICIA B. SUTKER, CHIEF,
PSYCHOLOGY SERVICE, NEW ORLEANS VA MEDICAL CENTER**

Dr. SUTKER. I appreciate the opportunity to speak to you today. I cannot speak for the overall population of veterans. I'm going to talk a little bit about the research that I'm doing at the New Orleans VA with former prisoners of war, something about the research that we're doing with returnees from Operation Desert Storm, and comment briefly on our PTSD programs.

Basically, my message to you is one I think you already have expressed. There is a price to pay for war, and the price is that if people are fortunate to return from war, they then must pay a price later, and the research that we have done with the former prisoners of war, particularly World War II and Korea, shows that the price is heavy and burdensome indeed and does not relinquish itself with time and does not remit over the passage of time.

We have now a comprehensive data base of approximately 250 former prisoners of war. We have administered neuropsychological tests and tests of psychopathology. We show rates of PTSD and other major psychiatric disorders in 42 percent of men who were held by the Germans, 68 percent of men who were held by the Japanese, and 83 to virtually 100 percent of the men who were held by the North Korean and the Chinese.

The brutalities that these men endured have ruined their lives in some ways. It has reduced their emotional spontaneity. It has made their relationships with others less pleasurable and effective. It has caused them to live lives that have been damaged psychologically, and I think that the data are showing that this is a serious price that we have not necessarily recognized—even these men failed to recognize—until they reach the seventh and eighth decade in aging, and the problems really are obvious.

Similar data are coming from the returnees from Operation Desert Storm, and as we know, the price that you pay in terms of psychopathology is a dose-dependent relationship, and more psychopathology is apparent when the stressor is more severe. So, for example, in the Operation Desert Storm people, those who were assigned graves registration duties show the greatest amount of psychopathology. Rates of PTSD are appearing in the men and women who served graves registration duties at the rate of 46 to 48 per-

cent. Virtually half of them, within 1 year, show full PTSD on a structured, individually administered interview.

I think this is proof positive that when we bring our men and women home from military operations, it is time for us to see what we can do about helping them heal some of the wounds.

One of the things I wanted to say is, among POW survivors, among combat veterans and veterans of these more recent military operations, if the criterion for recovery is freedom from scars, the absence of wounds and psychological discomfort, or return to pre-war levels of functioning, then the prospects are grim. So it is indeed a chronic mental illness.

In New Orleans we have been fortunate enough to develop several PTSD programs so that we can treat the residuals of war. We feel that PTSD is a war-related diagnosis. We feel that veterans of Vietnam, who have rates of 15 percent and 31 percent for current and lifetime rates, have been overlooked, but we also feel that the veterans of Korea and World War II have been overlooked, and we're afraid that the veterans of Operation Desert Storm and other military operations, such as in Grenada or Lebanon or Panama, will also be overlooked.

So we're delighted to be here today to just provide perhaps some data that may be helpful to you all in your quest to provide the veterans of our country who went to war with some assistance so they can pull their lives together. The one thing that these people want to do is they want to work. They want to live effective lives. They do not deserve the publicity that they are coming to the VA for a handout. What they're coming to the VA for is for some compassionate mental health assistance.

That's what we're trying to provide in New Orleans, that has been the leadership of Dr. Paul Errera, and we are appreciative of the efforts of the Congress to provide money for these men who have been fortunate enough to return home, but have many problems to deal with upon their return.

Thank you for the opportunity to speak with you today.

[The prepared statement of Dr. Sutker appears on p. 91.]

Chairman ROCKEFELLER. Thank you, Dr. Sutker.

Dr. O'Brien.

STATEMENT OF DR. CHARLES P. O'BRIEN, CHIEF OF PSYCHIATRY, PHILADELPHIA VA MEDICAL CENTER

Dr. O'BRIEN. Good morning, Mr. Chairman. I'm Charles O'Brien, Chief of Psychiatry at the Philadelphia VA Medical Center, and Professor and Vice Chairman of Psychiatry at the University of Pennsylvania.

I've observed the toll taken by substance abuse and other mental disorders while on active duty as a U.S. Navy physician and, for the past 22 years, as a VA physician. Mental problems are very severe among the population of veterans who come for help to our VA medical center. On any given day, more than 50 percent of the patients on our medical and surgical wards are being treated for complications of some form of substance abuse, either nicotine dependence, alcohol dependence, cocaine dependence, or heroin dependence. It seems that among U.S. military veterans, those suffering from mental disorders, including substance abuse, are more likely

to seek care in a VA facility than those who are mentally healthy and likely to be covered by private health insurance. Many of our patients suffer from substance abuse in combination with other psychiatric disorders, such as schizophrenia, depression, or post-traumatic stress disorder.

A gradually increasing proportion of our patients are in the geriatric age group, and among our aging veterans there is a very high frequency of behavior disorders. I was just told yesterday by the Chief of Nursing that the major reason for nursing lost time at our Nursing Home Care Unit is because of attacks by elderly patients on nurses and other staff, and they're disabled because of these violent attacks. Clearly we've got to have more psychiatric care in our nursing home.

We also have the direct complications of aging, such as Alzheimer's disease, as well as those psychiatric disorders, such as schizophrenia, that begin in youth and continue into the senior years. Recently, we've been finding increasing numbers of geriatric patients whose medical problems are caused by or complicated by substance abuse in the elderly population—usually alcoholism.

In Philadelphia the Psychiatric Service has 75 beds, which average near 100 percent occupancy. In fact, we spend a lot of our time trying to find space for all of the veterans who come in as psychiatric emergencies. We have an extremely active emergency room that operates 7 days a week, 24 hours a day, and anyone who is thought to be a veteran anywhere in the Philadelphia area is brought to our ER by the police if they have a psychiatric emergency. There are so few facilities for poor people with psychiatric emergencies whether they're veterans or not.

We serve in Psychiatry alone over 130,000 outpatient visits per year, which is over half of all outpatient visits for the medical center. We also have large subspecialty programs for the treatment of post-traumatic stress disorder, geriatric psychiatry programs, and substance abuse programs.

Now, in research, the VA has a very proud history of research accomplishments. I'm speaking nationally. Many of our current—

Chairman ROCKEFELLER. Dr. O'Brien, can I interrupt? And the light will be held against me, not against you.

The resource-based relative value scale is, although complicated in name, well-named, and if it was meant to prove anything objectively, it was that cognitive time spent needs to be rewarded as well as, let's say, optimal time. Now, are there any two areas—and I know that psychiatrists and psychologists sometimes do not join hands on all things—but are there any two areas that are more cognitively intensive and thus less subject to the relative value scale that the public applies to them than those two areas? I'm going to ask this kind of question later, too.

Dr. O'BRIEN. I think that you've hit it right on the head, because I have responsibilities at the university hospital as well as at the VA, and I can tell you that this relative-based value scale is a huge problem, because in areas of psychiatry and psychology, in evaluating and especially in the long-term treatment of mentally ill patients, we have a huge problem. As you point out, this work requires intense cognitive effort, intense one-to-one and family and group time that is really not adequately compensated, in my opin-

ion and in the opinion of many others who evaluated this, according to this relative value scale.

Chairman ROCKEFELLER. I'm not even talking about the compensation, but do you know of any other pursuit or activity or profession within medicine in which there is more time required for patient care than in these two areas?

Dr. O'BRIEN. Well, I have to be completely honest and frank about this. I'm also trained in internal medicine and neurology, and I can tell you that there are a lot of very difficult diagnostic problems in these specialties that also require a lot of cognitive effort, but it's usually at the level of trying to make the diagnosis, not as much over the long-term. Once the diagnosis is finally made, then there is less of this intensive time required, whereas in psychiatry and psychology this effort is required over the long haul.

Chairman ROCKEFELLER. Thank you, and I apologize.

Dr. O'BRIEN. Well, I just wanted to say a few words about research in the VA. As I was about to say, many of our current treatments in cardiology, gastroenterology, and surgery have been developed through VA collaborative studies. As you pointed out in your opening statement, the VA has the largest health care system and is ideally suited to do these studies. In fact, it has really profited health care, and, I might add, not just in the United States, but across the world. The whole world has benefited from VA studies. In the psychiatric field, many of the important antipsychotic medications were developed in VA studies.

Now, in Philadelphia we have a very large psychiatric research program that's funded not only by the VA, but also by the NIH, such as drug abuse, alcoholism, and mental health. We are also coordinating a large multicenter effort to develop new medications for mental illness, especially in the area of addiction, and this involves both VA and non-VA centers all over the country.

In the area of substance abuse, two medications that have been approved already by the FDA for the treatment of opiate dependence have been developed because of major contributions by VA research. Our research has developed the major measuring scale for addiction that is now being used not only throughout the VA, but also throughout the United States and in many foreign countries. It's been translated into seven different languages. Again, a VA scale. New treatments for alcoholism, for opiate dependence, and for cocaine dependence have been pioneered by our VA research program. We have conducted numerous studies comparing the cost-effectiveness of various treatments.

These controlled studies, using random assignment to different treatment modalities, have shown that most alcoholics and other drug-dependent patients can be treated effectively in outpatient programs at far less cost and sometimes even more effective treatment, because of the fact that it goes on for a much longer time, and rehabilitate a larger proportion of our patients with these outpatient programs. The results of these studies conducted in veteran populations have been published in medical journals and have influenced the treatment of substance abuse right across the board in the United States, and they've been widely quoted.

Our teaching programs involve students of medicine, nursing, social work, psychology, as well as residents in psychiatry and NIH

research trainees from our own medical school and from other medical schools throughout the country. We have, as I mentioned, a close academic affiliation with the University of Pennsylvania, and I can't emphasize how important that is for us in recruiting high-quality professional staff for our VA. That academic affiliation is critical.

I'd like to thank you, Mr. Chairman, for the opportunity to discuss these issues, and I'd be happy to answer any questions that you have.

[The prepared statement of Dr. O'Brien appears on p. 92.]

Chairman ROCKEFELLER. Thank you, sir.

Richard Greer.

STATEMENT OF RICHARD T. GREER, MEMBER, SCIENCE REVIEW COMMITTEE, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mr. GREER. Thank you very much. My name is Richard T. Greer. I am a veteran of World War II. I have also a son who, now age 30, has been disabled by mental illness since childhood. I have been former Director of Government Relations for the National Alliance for the Mentally Ill, and Deputy Director at the time I retired. Ill health forced me from that active career, which was very fulfilling to me, and I now spend my time as a volunteer advocate, with the personal goal to improve services for severely mentally ill persons at local, State, and Federal levels.

We are the families of veterans who care deeply about access to care and the quality of care of our veteran family members. Many of us have become very knowledgeable about good care, including good services. We see many of the same problems in the Department of Veterans Affairs that we find in our States and in our communities. The more we hear from our membership and examine VA performance in the mental health area, we find problems similar to those in our so-called public system.

Here's an example: More than 80 percent of VA mental health dollars are spent on inpatient care while the need for increased outpatient and community-based programs is amply documented. There ought to be a shift of many of these dollars to achieve state-of-the-art care and treatment in the community and an incentive to reduce expensive inpatient care. We've got a similar mismatch in most of our States. In my State of Virginia, for example, the split is 70/30—30 cents goes to the community, where 9 out of 10 mentally ill people are, whereas 70 cents stays at the State level for our State facilities, where only 1 mentally ill person of 10 is.

It's clear that the Department of Veterans Affairs hasn't assigned significant priority to veterans who are severely and persistently mentally ill. Forty percent of all veterans treated by the VA have psychiatric disorders, a high proportion who have service-connected schizophrenia, but have never been given a priority. Why is it that although psychiatric patients make up more than 43 percent of all VA inpatient care days, less than one-fifth of the VA inpatient dollar goes for this care? Is there stigma in this system, too?

It's common knowledge to us that accessing the VA system by our veteran family members is problematic. Eligibility is a roll of the dice, and if you're lucky enough to gain outpatient eligibility,

you're lucky if you can find the service on a timely basis. Is this why veterans constitute such a high proportion of homeless adults?

I'd like to call your attention to a new book just out called "A Nation in Denial: The Truth About Homelessness," and, Mr. Chairman, you would be interested to know that Alice Baum and Donald Byrnes, the authors, live in Berkeley, West Virginia. They document persuasively that 41,000 homeless persons are Vietnam veterans out of an assumption of a national total of 600,000, a high proportion of these suffering from alcoholism, drug abuse, or mental illness, or a combination of the three. Another 80,000 veterans are from the era before Vietnam or after Vietnam.

The thesis of this important new book is that up to 85 percent—and they're using the studies that are out there, not coming up with new numbers—85 percent of the homeless adult population in America includes persons afflicted with alcoholism, drug addiction, or mental illness, or a combination of the three, and here's their main point: that they are homeless not because they need housing or because the economy has been in low gear, but because the treatment for these disorders has not been available.

We want you to know that we enthusiastically support your bill, and we support Senator Akaka's bill. It's a timely and good bill. Improving services to research and training and developing improved methods is desperately germane. So badly is it needed that I wish you'd increase it from five centers and increase the authorization to a higher level. We think that the advisory committee ought to include families and veterans. We'd like to see the PACT model, which our longer statement talks about, included somehow in these new centers and their experimentation.

You have someone from the Bay Pines, Florida group on your panel, I'm delighted to see, who will speak how our NAMI groups around the country can interface with VA medical centers and help in transitioning people into the community.

Thank you very much.

[The prepared statement of Mr. Greer appears on p. 92.]

Chairman ROCKEFELLER. Thank you very much, Mr. Greer.

Maybe I could just throw out a general question to begin with, and all of you are welcome to respond. Please say hello to Donald Cohen for me, will you? I spent 4 years working with him on the National Commission on Children, and I watched him in a former crackhouse in Los Angeles take a terrified 4-year-old child, a little boy, with 15 or 20 commissioners and a couple of TV cameras watching, and so completely calm the boy, take control of the boy in a constructive sense, that the boy began to talk about the demons that had entered his 4-year-old life. It was an extraordinary thing, and he's an extraordinary person.

If you take the proportion of doctors to patients as being extremely low in the case of psychiatry, 1 to 49, compared with 1 to 15 for surgery and 1 to 22 for general internal medicine, while the standard for psychiatric outpatient visits is usually four to five times longer than the average medical visit—well, now, you get the point I'm trying to make. As a lesser question, how can we correct this? That's not a lesser question, but I'm more interested in the answer to my second question first, and that's the question that you all referred to even when you didn't, the question of stigma,

of America being uncomfortable with the concept not just of mental health, but of chronic mental illness.

It's been interesting to watch in the national health reform effort that some businesses, for example, mostly small businesses, routinely say that mental health has to be frivolous by definition—stress and all the rest of it. I mean, it just is tossed away out of hand, yet very compelling statistics are given as to the number of veterans who are on the streets. Not just the question of alcohol and drugs and the rest of it, but schizophrenia, which several of you referred to. My colleague, Daniel Patrick Moynihan from New York, has always maintained that schizophrenia rules the streets of the homeless. He's a sociologist and a brilliant man not trained to answer that question, but that's his theory.

So my question is in recruitment, and it's the same question, of course, that you run up against in terms of another area—primary care. Why can't we get more people to go into those areas that relate to mental health? I am told that in the 1960's, 10 percent of graduating medical students selected psychiatry as a specialty, and now we're down to 4 percent. I would just like for each of you, if you care to do so, to reflect on that problem, because that, in turn, means that there's a smaller pool or that the Department of Veterans Affairs is more or less able to get those people, and who's offering what kinds of salaries, and the cross-fertilization of residency in VA hospitals, which is important, which some of you have referred to.

I'm interested in the concept of stigma. I hate even to have to bring that up in 1993, but we do. You've mentioned it yourselves. How are we progressing on that front?

Dr. LIPKIN. Senator, if I can comment on the recruitment and the stigma together, without being totally facetious, there seems to be no shortage of proctologists in the world. I think the reason that there is a shortage of psychiatrists, in contrast, is that both in medical research funding, in curriculum time in medical schools, and in terms of reimbursement for services, medical students follow Sutton's law—that is, they go where the money is. Until primary care in pediatrics and primary care in internal medicine and psychiatry earn what amounts to the average physician's salary, they will be harder to recruit for. I think it's really basically a matter of either lowering one end of this scale or raising the other.

Chairman ROCKEFELLER. Can I put up another thesis just to enrich the conversation? I agree with that. West Virginia is not a big State, and it's not a rich State. We have three medical schools. We cannot afford three medical schools. They have refused to cooperate, or, more importantly, they have refused to teach—for example, to have the professors and the students go to rural health clinics in rural settings so that people can be exposed to rural primary care, rural problems, but basically, primary care. Along comes the W.K. Kellogg Foundation with \$6 million, and they say to us, "You match it." I was Governor for 8 years. I couldn't pull this off. They say, "For \$6 million, a paltry sum, you match this, State of West Virginia, and we will cause these three medical schools to do and teach primary care in rural areas and in rural community health clinics."

Now, the result of that, as in the case of the National Health Service Corps, is that often students who are in their mid-20's—yes, they have enormous debts, and, yes, they have house mortgage payments, and perhaps they're married and have children, but, yes, they're also human beings that are at the most idealistic time in their life, and money is not everything in their life. Many of them, indeed—as I chose, when I went in 1964 to West Virginia, at the age of 25 as a VISTA volunteer, without any intention of staying, and it's now been 29 years. I went because I felt I could make a difference. This happens in primary care, and, therefore, why cannot that happen in psychiatry and psychology? Why the difference? I don't accept that money is the only answer, although it certainly is a big one.

Dr. CHARNEY. Mr. Chairman, that's a very important question. I think one of the issues related to the answer is the difficulty of our patients at this point. In my own career, I have found that, compared to when I started out, the severity of patient illness has increased dramatically. We are dealing now with more violent patients, patients with dual diagnoses, meaning psychiatric illness and co-morbid substance abuse. It's more of a challenge, and that is part of the reason why it's been more difficult to recruit new physicians into the field.

That's somewhat a contradiction of the excitement that the field also feels right now, particularly in terms of understanding how the brain works, developing new treatments, like Dr. O'Brien mentioned. This is a time of extraordinary promise. It's been designated the "decade of the brain." So, on one hand, we're dealing with a very severe group of patients; on the other hand, we have now the ability to apply new treatments to help their lot and perhaps even some society problems, like homelessness.

Another thing that we're faced with that is maybe even more difficult is what we've all mentioned, which is the stigma. I don't think it is conceivable that a situation would exist in internal medicine and surgery in which they're doing 40 percent of the work and getting 20 percent of the funds. It just would never happen. We are concerned now that the situation could get even worse if specially designated programs no longer have funds attached to them. We don't have the same kind of support within our medical center and medical school environments to support these programs.

So when you take in conjunction the stigma that we're still faced with, the difficulty of our patients, our problems in recruitment and maintaining a high quality of care become more understandable.

Chairman ROCKEFELLER. Please, sir.

(Subsequently, the Department of Veterans Affairs provided the following information:)

DUAL DIAGNOSIS

BACKGROUND: Patients with both a substance use disorder and another psychiatric illness are commonly seen throughout the VA medical system. These patients have a "dual diagnosis," are difficult to treat, and often consume a disproportionate amount of resources.

The psychiatric problems that are seen include acute, drug-induced organic mental states as well as psychiatric disorders that are independent of the pharmacologic effects of the abused substances. Both types of conditions may require hospitalization, especially when homicidal or suicidal ideation occurs. The drug-induced disorders usually resolve quickly, but the independent disorders usually require longer

term treatment. In every case, treatment of the psychiatric disorder must be integrated with treatment of the substance use disorder.

The high proportion of dual diagnosis patients that are seen among veterans is consistent with the findings of epidemiological studies, which have found very high rates of comorbid psychiatric disorders among persons with substance use disorders. The most common diagnoses are affective disorders especially major depression, anxiety disorders, post-traumatic stress disorder, paranoid disorders, schizophrenia, and antisocial personality disorder. Independent psychiatric disorders that have been shown to occur at greater-than-expected frequency among substance-abusing patients are schizophrenia in alcoholics; post-traumatic stress disorder, especially among Vietnam veterans; attention deficit/hyperactivity disorder in persons with stimulant dependence; and antisocial personality disorder, especially among persons with opiate dependence.

STRATEGY: An emerging body of work has shown that persons with dual diagnoses can be helped considerably by providing psychiatric care that is fully integrated with substance abuse treatment. Treatment programs typically involve professional psychotherapy, family therapy, pharmacotherapy, and behavioral therapies that are combined in various forms with substance abuse treatment.

Treatment typically occurs in one of two settings: (1) a mental health clinic or, (2) a substance abuse treatment program. Assignment of patients to one or the other program is usually done on the basis of the most prominent disorder. For example, a person with a long history of schizophrenia who abuses cocaine but is not dependent on it is typically referred to a primarily mental health setting; a similar person who presents with cocaine dependence but who also has schizophrenia is often referred to a substance abuse treatment program.

Long-term management of these patients can usually be accomplished by properly-staffed outpatient programs. In the case of mental health clinics, staffing involves adding a substance abuse treatment component to the ongoing mental health therapy. In the case of substance abuse treatment programs, psychiatrically-trained staff and therapies are added and integrated with the ongoing substance abuse treatment. Inpatient backup is required as crises involving acute psychiatric symptoms or uncontrolled drug abuse will occur in either setting.

Dr. O'BRIEN. I completely agree with many of the comments that have already been made about the economic issues, and I'm very optimistic about our improving our ability to recruit people because of all this excitement that Dr. Charney mentioned. I mean, I think actually at Penn we're starting to really improve with the medical students going into psychiatry because it's become so much more of a scientific specialty.

But the other part of your question I don't think has been adequately addressed, because I don't believe that it is the lack of psychiatrists in the pool of physicians that is causing this problem. I think that it's more, if you will, the stigma issue or whatever. There's some sort of a decision that's been made sort of implicitly not to fully fund some of the mental health needs of these patients. I think psychiatry sort of at the overall level of designing a health care system is not as sexy, it's not as impressive, and so people want to have open heart surgery and all sorts of scanners and stuff, and psychiatry is relatively low-tech.

I think that in the long run the VA health care system, if it's going to survive in the future health care system of this country, is going to have to recognize that there are certain things the VA does well, does better than anybody else, and I think it has to do with chronic care, chronic mentally ill, elderly folks, substance abuse people, and it's not going to be open heart surgery or really high-tech stuff.

At our hospital—first of all, I've been recruiting psychiatrists for my program for over 22 years, and there was a period of time when our pay was very poor relative to the rest of the community, and I had a lot of vacancies. I don't have vacancies now. I don't have

enough slots now to take care of the patients, and I don't have enough beds. I don't have enough residents. We have about 110 residents at our hospital and only 6 psychiatric slots, yet psychiatry is the area that's full all the time or overfull. We do, as I told you before, half of all the outpatient visits, but we only have these six residency slots.

So I think that it's not just the choice of physicians going into psychiatry, but it's something having to do with allocation of resources within a health care system.

Chairman ROCKEFELLER. Yes, sir.

Dr. FRIEDMAN. I would certainly agree with my colleagues. I think that an important area that needs to be discussed is the question of incentives. I think there are a number of disincentives for people going into psychiatry, and I'm very hopeful that the discussions about national health care can perhaps change our priorities and also change the incentives for people going into this field.

One of the problems, I think, in psychiatry is that there is a two-caste system for psychiatric patients. I think that with all the good things that the community mental health movement did back in the 1960s by providing care for psychiatric patients, it also created Brahmins and sweepers in terms of patients. Only the mental patients were given a different kind of care in a different system. Poor people with surgical problems were still provided the same kind of treatment as wealthier people in the same medical centers.

When we speak about medical students, I think their perception of psychiatry in contrast to other medical specialties affects recruitment and I agree with you entirely. I think salaries are important, but this accounts for only a small part of it. I think some medical students are idealistic, and I think if psychiatric work is valued from a social policy perspective and if there are better work-related incentives such as more favorable patient-to-staff ratios, in terms of workload, and if opportunities to conduct psychiatric research could be made more comparable to such opportunities in other medical fields, that the high cost of medical education and all the other things that have been mentioned, would be less of a stated reason for people not going into psychiatry.

Chairman ROCKEFELLER. Dr. Lipkin.

Dr. LIPKIN. I wanted to comment a little further on the recruitment question. If you work in Philadelphia or at West Haven, you have the benefit of the really elegant and productive academic and research process that is an enormous fringe benefit. If you work at a Perry Point or a lot of other hospitals in the VA system, what you have is quite different. Not only are the relationships between the number of staff and patients different—staff/patient ratio—but the overall staffing situation is different.

We have three vacant slots, I think, right now. We pay enough money, but people come and look very carefully at working in our hospital and decide that the working conditions are, one, better in the State or Maryland, which is stunning, because state programs are not well funded and, two, they're better in a variety of kind of patched-together other activities, i.e., several part-time jobs. There's a particularly interesting young woman who has just graduated from Johns Hopkins who we've interviewed, who can't make up her mind whether to come and work for us or not. Part of her

hesitation is because she wants to do outpatient work. At the present time, we don't have enough slots to give her an outpatient job. We can only give her an inpatient job. If we had half a dozen slots to spare, we'd say, "Sure. You're a worthwhile clinician. We've got plenty of work for you. We'll do what you need to do to come and work here."

There is a real difference in how mental health services are staffed across the system, whether it's Philadelphia or West Haven or Perry Point, and it's quite tangibly different from how medicine and surgery are staffed. I think that's another thing. Any medical student who sees that during his or her training years says, "Do I really want to be that much of a hero?" When I was in training, it wasn't quite so clear that that was the issue. I sort of figured I was going to be a psychiatrist anyway, so maybe I didn't do it in as thoughtful a way as some of my younger colleagues do when they owe hundreds of thousands of dollars. But the message is real clear: Be a first-class doctor, become an internist or a surgeon. Be something else, become a psychiatrist. So we need to change that.

Chairman ROCKEFELLER. I have lots of questions, but we have five panels, so I'm not going to be able to ask them all. However, you're going to get them all in writing, and I would appreciate if you could respond to them within the next 2 weeks, if possible. These are the questions that I will not have a chance to ask today because we have five panels.

Taking off from that question, we just finished something called reconciliation yesterday. You do not want to know about it. It's a very messy process. You do not want to understand America as you look at Congress doing reconciliation. But one of the things that we did not do in that process, although there has been a bill submitted by Henry Waxman and myself, was to set policy in terms of graduate medical education and indirect medical education which has tended to go high-tech. I'm talking about the \$5.5 billion that Medicare gives to teaching hospitals, which is, in essence, a direct reflection of public policy. We have decided that in our ignorance or our passivity, whichever. It doesn't make any difference. But what we want to see, obviously, is, by the year whatever, a 50 percent ratio of primary care doctors to specialists. That's what we need in this country. Germany does better, but a 50/50 ratio is good enough for us.

Now, we can only do that if we in fact use Government dollars to cause Government policy. This could be threatening to you, and that brings up the whole relationship between mental health, chronic mental illness, and primary care. What this bill says is that after a period of 5 years, you must be able to demonstrate that you are making a good faith effort to produce a 50/50 ratio. Obviously, it takes time to readjust. We all understand that. It takes time to readjust faculty, facilities, and the rest of it. But after 5 years, if you're not doing this, you don't get any money from the Federal Government. You just don't get any.

So, I need to ask you the question of the relationship, as it's understood by you and as it's understood by others who may know less, between primary care and mental health and chronic mental illness. Will you be the victims of nonthinking on our part by this bill?

Dr. LIPKIN. There's a possibility, Senator. I think of psychiatry as a primary care specialty, like family practice and pediatrics. I think that's the only sensible way to do that.

Chairman ROCKEFELLER. So you think of it, but is there a world of literature out there which says it?

Dr. LIPKIN. There's some, but I'm not sure there's a majority of physicians who believe it.

Chairman ROCKEFELLER. You better start writing some articles.

Dr. LIPKIN. Sir?

Chairman ROCKEFELLER. You better start writing some articles. I'm serious. I see this as a threat to your field unless you can identify—and I see it as very reasonable—early signs of mental health. I mean, I talked about the 4-year-old kid. I'm not a physician, I'm not a psychiatrist, I'm not a psychologist, but I would think that this would be something which could be shown fairly easily. So, what will happen?

Dr. LIPKIN. If you all make the policy, of course, what happens is we make plans and get consequences. It's one of those things that I hope will be cleanly defined in the legislation so that the consequences aren't totally a surprise to all of us.

Dr. FRIEDMAN. It's my understanding that the American Psychiatric Association has argued that point and has continued to argue the point that psychiatry is, de facto, a primary care specialty. Tipper Gore addressed the APA this spring, and she also indicated that has been discussed in the discussion about national health care policy. I certainly agree with that completely. I think particularly as we are in the decade of the brain, psychiatrists find themselves working more closely with people in our sister specialties on the one hand and functioning more as primary care specialists on the other. It really is almost an obvious point that psychiatry has become a primary care discipline but perhaps we haven't made a good enough argument to convince others on that score.

Chairman ROCKEFELLER. Please, Dr. Charney.

Dr. CHARNEY. I think perhaps the best argument for psychiatry being a primary care specialty is in relation to public sector psychiatry. I don't think there's any question that the patients that come to our State mental health facilities and many of the patients that come to the VA, their primary doctor is their psychiatrist. They don't go to an internist, they don't go to medical/surgical specialty doctors. They come to psychiatrists for their care, and it's a psychiatrist that manages their total mental and physical health care. It may be different in the private practice sector, but in public sector psychiatry we are the primary care physician.

Chairman ROCKEFELLER. Let me conclude my questioning. Senator Simpson has arrived and sometimes wants to add a comment or two.

Would you care to this morning, Senator Simpson? I'm so happy you're here, sir. I've been left all by myself, and I've been missing you greatly. [Laughter.]

OPENING STATEMENT OF SENATOR SIMPSON

Senator SIMPSON. I know the nature of your lonely quest here because I sat right there, and Al Cranston sat right there, and no one

would come. When I took over, no one would come. It's called being Chairman.

Well, I thank you, Mr. Chairman. I have a statement, and let me place it in the record.

[The prepared statement of Senator Simpson appears on p. 81.]

Senator SIMPSON. I would just say that I remember so well when we started the Vet Center program. The purpose of the Vet Centers was to treat Vietnam veterans and there were many who didn't think the Vet Centers were appropriate because they were just an appendage outside the VA. Yet all of us, including myself, became a believer that certainly the Vietnam veteran did not want to deal with people in the VA. They were alienated from the VA, and they didn't want any part of that system. The VA was seen as the "guys in the white coats" who drove them goofy, and Vietnam veterans didn't like them.

So we set up the Vet Centers, and at first I did not think it was the thing to do. Then I went to several Vet Centers and I participated in their counseling sessions and their briefings. I saw some in other States, and I thought it was one of the finest things that we've ever done, and still do. But that war is over, and it's been over now for 17 years. But now do you open these centers and begin to treat, as I understand some of this legislation, veterans of World War II, Korea? What is the purpose of that when you have this huge VA system?

This is a total duplication. It's good politics. It's good emotion. But it is absurd. Absolutely absurd. It doesn't fit. That's my view. We do so much in this Committee out of some almost obsessive driving force to think we've done nothing for veterans in America, and that is absurd. I used to carry a list around in my pocket of what we do for veterans and what we specifically have done for the Vietnam-era veterans and now what we're doing with regard to Persian Gulf veterans. I think at some point in time you're just picking the pocket of other programs within the Department of Veterans Affairs. I think that's wrong. We just vote for everything in this Committee.

It's not your fault, Mr. Chairman. I've been on this Committee for 14 years. Just mention the word "veteran," and get out of the way. At some point in time, somebody's going to have to establish some priorities in veterans' benefits. Somebody's going to have to truly study our current system of benefits because it can't continue like it is today.

You want to remember who really drives this. The veterans' organizations drive this, because as we have less wars, there will be less members. As we have less people in the military, there will be less veterans. So their job is to try to broaden and broaden and broaden beyond comprehension just so they can keep the membership up. That's a very important part of it.

I'm a member of three of those groups—VFW, the Legion, and AMVETS—a very proud member, but at some point in time we never seem to hear from the combat veterans, the people who really laid themselves on the line. We hear from the administrators, the promoters, the guys who served the least and want the most, and Congresspersons who will never say no, else they will be painted as evil, antiveteran, uncaring people in the Congress.

So I just say I can't imagine—if Al Cranston were here, he would be appalled at this proposed expansion—because the Vet Centers were for veterans of the Vietnam war to deal with post-traumatic stress syndrome and an alienated veteran population. They have been handled beautifully and fairly and generously.

I would like to enter into the record an article from Stars and Stripes. I think it is a powerful grassroots statement. I admire what you're doing, Mr. Chairman, but part of the job is curtailing the unnecessary growth of these programs. I know you went through a difficult budget process, and you had to correct what we did, which is where we just voted for the bucks, and then you had to go "into the tank" and figure out where to make the VA budget really work. Why don't we do it here, and then we don't have to send our Chairman into combat to slice money. Any temporary program we've ever done here has become permanent. This is a classic example.

So I just think that at some point the purpose of the Committee—and I respect you greatly and will work to assist you vigorously, but at some point in time the word "no" has to enter the vocabulary, and I don't know where that is, but if the Vet Centers were ever intended to open to these veterans, I can't even imagine it.

So I thank you for your charitable, gracious listening, and I do admire you so, and I know that you're in a Committee where all day long they're just hammering on you. Hammering, hammering, hammering, and it does get tedious.

Thank you.

Chairman ROCKEFELLER. I'm a happy man, sir. [Laughter.]

Senator SIMPSON. I know. So am I.

Chairman ROCKEFELLER. You gentlemen and ladies have heard what the Senator has indicated. We've discussed this subject this morning, and perhaps one of you wishes to comment on the thrust of his remarks.

I would prefer, sir, if we could have one of the professionals from the VA.

Dr. FRIEDMAN. I've not been involved in developing the legislation, but from a PTSD perspective, I think that a concern of those of us that have learned that PTSD is not just something that happens to Vietnam veterans—and as I said before you arrived, Senator, it's something that happens to older veterans from other wars and to veterans and civilians who were exposed to other kinds of trauma, such as industrial accidents, natural disasters, domestic violence and violence in the inner city. A major problem that we have been helpless to do much about has been that as the tightening eligibility standards within VA, which limit access to treatment, continue to tighten, people with war zone-related PTSD and other post-traumatic problems don't have adequate treatment options for trauma-related problems. I think that VA is clearly the top place in the country, if not the world, in understanding and treatment of post-traumatic stress disorder, and yet we have people who were in a war zone who have PTSD who don't have the eligibility to come to our VA medical centers, although we have excellent programs scattered across the country.

Those of us who sit in hospital-based offices are quite gratified that the Vet Centers that do not have the same eligibility constraints as VA medical centers are available to provide this type of counseling for veterans, and I think that for that reason it's important that this legislation be presented.

Chairman ROCKEFELLER. Senator Simpson, before you came, there had been an outpouring—and I'm actually interested, Dr. Friedman, that you were the only one who was willing to speak up on this. I don't draw conclusions from that, but there was an outpouring of feeling, in fact, that World War II, Korean war veterans—these are professionals, they work for the VA, they could make more money elsewhere—there was an outpouring of feeling that, in fact, the whole understanding of this problem has been grossly underestimated, that we're just beginning to uncover what lies in post-traumatic stress disorder. I'm not myself an expert on it, but they all commented, but then few wanted to rebut you.

Senator SIMPSON. No, no. Mr. Chairman, what lies in the course of all of our lives since 1945? Surely somebody has to recognize that if somebody was in the service in 1943 or 1944 and it's 1993, that they've been through all the riveting, sandblasting processes of life. Now, is whatever has happened to them at this point in life due to what happened in 1943? I don't believe that is so. Anyone can tell me that, oh, yes, that's true, and at some point in time those people in different wars may have suffered temporarily due to the nature of war. We had phrases for that terrible aspect of war. There was the phrase "shell shock." There was the phrase "battle fatigue." There were other phrases. It's vestiges of "war is hell," and that's the way war is.

But if we have a system where we put the bucks that we put into the VA and then say that it doesn't serve veterans for whatever purpose—physical, mental, psychological—then what the hell are we putting all the money into the VA for? That is absolutely absurd, these ancillary issues. Put them into the VA. Take these magnificent VA counselors and bring them into the system, or put them where they can assist. But this is not what this legislation is about, and the cost of it is going to take from the very veterans that need it the most. The older veteran who doesn't have PTSD or anything else, who served in combat, had a piece of himself shot off, and he is now looking for the proper pensions and disability and so on, will not find that help available. Because the money is being diverted to a cadre of people who don't want to give up the great role of "counselor."

Now, there are some aspects of the Readjustment Counseling System that are very real, so no one in the VA is ever going to tell me anything that won't be appropriate as they kick each other under the table and gasp and choke. I've been through this for years. Fourteen years. Can't speak. "I'd like to, Simpson, if I could, but I can't." Get them out and have a drink, and you find out more stuff about the whole operation, and it's a huge bureaucratic, watch-out-or-you'll-get-your-butt-caved-in exercise.

So I know what I'm going to hear, but I just think, heaven's sakes, why would we parallel the VA system if we're putting all these tons of bucks in here and you have to go scrap like a dog to

keep the bucks up? Here are these diversions which cost us another billion bucks a year. It seems absurd.

Dr. LIPKIN. Senator, I think you combined several parts. I, too, some days wonder whether we need separate and parallel systems at this time. However, as a clinician who sees combat veterans on a regular basis, it's perfectly clear to me that there are people who have survived their invisible wounds by working too hard, maybe by drinking too much, maybe by being extraordinarily successful at their work, and then they did something unusual, like retire, or something unfortunate happened, like their spouse died, and the adjustment process that developed, among other things, uncovered the vast amount of unresolved trauma that they experienced during the war that they participated in for this country.

When you talk about the amount of money that's poured into the VA and why we're here defending, if you will, the Readjustment Counseling Program, the issue is, in part, that in 1979, when readjustment counseling started, it was, to some degree, limited by the budget. As with other services in the VA, there are a number of things that are limited by the budget, and so, of course, we do need, from our perspective, to expand what we do, because we've never been able to do all that needed to be done. If we had been able to and had done it, which is kind of what you implied, and were finished, I would be in total agreement with you that it would be time to change. But we're not done yet, sir. We have a long way to go to finish the job that we've been asked to do.

Senator SIMPSON. But, Dr. Lipkin, the job is not finished, but there are going to be less people to do the job for. Anyone that doesn't understand that in these times when you have a reduced military, you'll have a reduced VA system. The only exercise in true combat since Vietnam has been Panama and Grenada and then, of course, the big one in the Gulf, and that's the reality of the status of the VA system today. Your money ought to be directed to figure out how to take care of the old vet, who's going to cost \$25,000 to \$30,000 a year. That is called long-term health care. Take care of that fellow or that woman. That's where the bucks ought to be going, instead of new and novel ways to just keep people going in something they enjoy doing, but something that's a duplication of what this huge agency is all about.

Dr. LIPKIN. Senator, the essence of my testimony is in agreement with you that we need to spend a great deal more money and a great deal of the existing VA budget on long-term medical and psychiatric care for veterans. But I'm also worried, because I know that the reason we have some very ill, very chronic World War II veterans is because we didn't do enough for them then, and I don't want to repeat that with the Korean war veterans and with the Vietnam veterans and with the Desert Storm veterans, and we're at risk for some of that if we don't do a better job with things like post-traumatic stress disorder in 1993.

Senator SIMPSON. Mr. Chairman, you're very gracious with me, but if we're going to talk—

Chairman ROCKEFELLER. You didn't know you were going to get such a starring role here this morning, did you?

Senator SIMPSON. I'm not trying to. I'm just so vexed to see this. I remember so vividly the original debate. But if we're going to talk

about those things and what we should do for Korean veterans and World War II veterans, then let the American people know that this year we're going to spend \$37.5 billion on veterans while the population is going down. Let the people really understand what the VA budget is. Let the people understand we're going to debate a health care package which is going to be tremendous in scope. Why don't we wait to include the VA system in the national health care reform debate?

We're going to continue to go back and just dig up through all previous wars—there's one I always like to throw in, especially as we hear the anguish of the POW issue and the MIA and the 2,346 missing soldiers. Well, will someone tell me what we're supposed to do about the 78,750 who were missing in action in the Second World War? Where does all this end? That's what I'd like to know. Where does it all stop? There are 78,750, including some of my loved ones, missing in action from the Second World War, and we're still picking each other apart about 2,300 from the Vietnam war. Where does it all end?

There are groups that gin up all the emotion in America, who send out mass mailings and get their membership dues. There are plenty of those in the veterans' organizations, too, who will send out another newsletter after today saying that "Jay Rockefeller and Simpson were there, and we hope they listened, because poor veterans of America get nothing except bum treatment from a bunch of guys who don't get it yet." That's crap. Real crap.

Other than that, I have no strongly held views. [Laughter.]

Chairman ROCKEFELLER. Senator Simpson, I'm going to have to cut this off, because we're still at our first panel, and we've got to go to our second panel.

I want to say that when Senator Simpson was talking about \$37 billion, he was talking about salaries, pensions, benefits, all kinds of things, not just what do we do in our VA hospitals. I want to note for the record that there was an enormous amount of passion expressed among the six of you on this issue when you were giving your testimony and as we discussed it; and when Senator Simpson, who is the second most powerful Republican in the Senate, came in, you wanted to speak, Mr. Greer, and I wouldn't let you. You were the first to volunteer. There was very substantial hesitation, and then finally Dr. Friedman and Dr. Lipkin did, but you did so in far more muted tones than you had before.

I will just say this to you, with the respect and the affection that I have for anybody who goes into not just medicine, but into psychiatry, which is 7–8 years after a college degree of study. Unbelievable work, unbelievable sweat requirements, lack of reimbursement, cognitive agony, violence, all of the things which you have described this morning. Your message this morning was that there are deep troughs of unresolved violence and distress, and it goes back to the Second World War and the Korean war, and you talked about Panama as well as Desert Storm; and yet when Senator Simpson came in here, you basically clammed up.

I'm not going to give you a chance, Dr. O'Brien, to say that now. You had your chance. And I'm not scolding you. I'm not scolding you, but I want to make an observation that we are all Americans. You work for the Federal Government, so does he, so do I. We all

get our pay from the taxpayers. When you have a chance to come down here and when somebody—I don't happen to agree entirely with Senator Simpson, although he knows there was one time that I was driving back with my wife from our farm 5 hours away in West Virginia, and he did an NPR radio interview that was so compelling that we pulled over to the side of the road for fear that we'd drive out of the distance. You know, NPR might not be covered in that part of Highland County, Virginia, or whatever. He's remarkable, and he has very strongly held views.

But the point to me this morning was you did not fight back to him. I want you to think about that. When you come down here to give testimony, if you believe in something, by God, you say that. If somebody comes and argues—it could be the President of the United States—it doesn't make any difference. You're professionals, and you fight it.

Now I will retreat from what I am saying, because then you'll say, "Well, that Rockefeller, it's easy for him to say that. He didn't grow up the hard way," and I'm glad I didn't, actually. [Laughter.]

But think about that. Think about that, and if you would like to write either Senator Simpson or myself, we would both welcome it. There are other questions which I didn't ask you, which I intended to, including one on research, but we are out of time.

Now, I apologize to all of you, and yet in a sense I found this very interesting and informative, and we've all learned from it, and I've got to thank you. Thank you very much.

I go now to the second panel: The ever-patient Hershel Gober, Deputy Secretary of the Department of Veterans Affairs, accompanied by Mary Lou Keener, General Counsel; Wayne Hawkins, Deputy Chief Medical Director; Dr. Arthur S. Blank, Jr., Director, Readjustment Counseling Service; and Dr. Paul Errera, Director of Mental Health and Behavioral Sciences, and who might have responded had he been in the first panel.

Hershel, your written testimony is part of the record. You are part of our Nation's forward movement. You came close—you were almost born in West Virginia, but had to settle for Arkansas. We're proud of you, sir, and we await your testimony.

STATEMENT OF HON. HERSEL GOBER, DEPUTY SECRETARY OF VETERANS AFFAIRS, ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL; C. WAYNE HAWKINS, DEPUTY CHIEF MEDICAL DIRECTOR; DR. ARTHUR S. BLANK, JR., DIRECTOR, READJUSTMENT COUNSELING SERVICE; AND DR. PAUL ERRERA, DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

Mr. GOBER. Thank you, Senator. It's a pleasure to be here, and I want to say this: I'm delighted that I came early and listened to the panel. Everyone told me that I was too busy to come and listen to the people that would precede me, but it was time well spent. I have become increasingly proud of the group of people with whom I work at the VA. The VA has some wonderful, dedicated employees that do a lot of good work, as everyone recognizes, I'm sure.

I'm pleased to be here, Mr. Chairman, Senator Simpson, and Senator Akaka, to discuss the Department's efforts to care for vet-

erans suffering from chronic mental illness. I'd like to begin by commenting on Senator Akaka's bill pertaining to our Vet Centers.

This bill contains a number of provisions affecting our Readjustment Counseling Service and the Vet Centers. We support many of the provisions of the bill. There are, however, two provisions that we believe merit further discussion and we're willing to discuss. Those two items of concern are the provision to expand readjustment counseling services to all veterans and the proposal to conduct a pilot program to furnish outpatient care through Vet Centers.

Mr. Chairman, we strongly believe that one of the reasons for the success of the Vet Center program is its focus on the treatment of stress disorders in combat veterans. While all Vietnam-era veterans are eligible for these services, most demand for them comes from those who actually served in Vietnam. This focus on war zone veterans recognizes the special readjustment needs of these individuals. To extend eligibility to all veterans would not only require more resources, but could change the nature of the program by making Vet Centers more like mental health clinics trying to meet the much broader needs of a wider population.

We believe that this provision could possibly result in diluting the effectiveness of the PTSD treatment we now provide. We would recommend that eligibility be extended to all wartime veterans who served in areas of conflict. In our judgment, that would allow us to provide the right kind of care for the people who really need it with current funding and manpower.

Mr. Chairman, our objections to the outpatient pilot program follow a similar line of reasoning. Our experience has taught us that these veterans are reluctant to come to us if they are made to feel like they are patients seeking medical care, as Senator Simpson indicated earlier. The Vet Centers are intentionally sited away from our medical facilities to avoid this impression. The veterans are much more likely to come into a relaxed, nonmedical environment to talk with counselors who may share some of their experiences.

Again, we believe that the independent identity of the Vet Centers has become fundamental to their success, and while we are fully aware that more and more medical care has moved from inpatient care to the outpatient setting, we strongly feel that establishing clinics in the Vet Centers would be detrimental to our Readjustment Counseling Program and our success with those veterans suffering from PTSD.

Mr. Chairman, I would now like to turn to the oversight issues before the Committee today. VA provides a wide array of services to veterans suffering from mental disorders. Most of the mental disorders VA treats are chronic, characterized by remissions and worsening conditions rather than permanent cures. A significant number of chronically mentally ill require substantially longer stays in the hospitals. Even with medication, therapy takes time, and there are no quick fixes.

We are currently witnessing a shift to noninstitutional care in the mental health field. Community-based care or outpatient psychiatric care is often more appropriate than inpatient care and can be more cost-effective. At VA, however, this trend is constrained by current eligibility rules.

Veterans with non-service-connected mental disorders, who also have low incomes, are eligible for VA inpatient treatment, but they are eligible for outpatient treatment only if it is to avoid hospitalization or in followup to institutional care. Consequently, many non-service-connected veterans either go without treatment or only receive inpatient treatment once their condition degenerates far enough. This Catch-22 situation must be eliminated.

Regarding the VA's Homeless Assistance Program, on any given night, over one-quarter million veterans are living on the streets and in shelters. We estimate that 40 percent of them suffer from mental illness. VA provides a variety of programs to assist homeless veterans, and our funding for these programs has increased dramatically over the last 2 years. Despite the priority that we place on these programs, VA does not have the resources to help every homeless veteran. That would take a combined effort by Federal, State, and local government, the private sector, and voluntary groups.

In the area of PTSD services, VA is an acknowledged leader in the medical field when it comes to treating PTSD. Our Vet Center Program has been a success since it commenced 14 years ago. Mr. Chairman, I recently visited a Vet Center in Beckley, in your home State, and I can testify firsthand to the dedication and commitment of the staff there. It is my belief that every dollar put in that program is money well spent.

Mr. Chairman, in summary, VA's Substance Abuse, PTSD, and Homeless Assistance Programs, which treat the homeless veterans with mental disorders or substance abuse problems, have success rates that compare favorably to non-VA treatment programs that work with similar, although usually less disadvantaged, populations. This is also true of VA's treatment of psychiatric patients.

Concerns have been raised about the treatment program for veterans suffering with chronic mental illness. VA has recognized the problem and is reviewing its program for treating this group, including the need to devote additional resources. In fact, during our August resource planning meeting, the entire planning meeting will be devoted to programmatic needs of chronically mentally ill veterans. We will be pleased to keep the Committee informed of our progress.

Mr. Chairman, this concludes my opening statement. I thank you for the time. I'm delighted to be here. My colleagues and I—probably mostly my colleagues—will be glad to answer your questions.

[The prepared statement of Mr. Gober appears on p. 99.]

Chairman ROCKEFELLER. Hershel, again, I apologize to you that you had to wait so long, but that was a very powerful first panel.

I guess I might just start out by asking—and neither you nor I are positioned, so we'll let others take care of these matters—about what Senator Simpson was saying. There appears to be a body of opinion that has surfaced, at least to me recently, similar to what Senator Simpson was saying about the Vietnam war having ended 17 years ago, and that we've got facilities to take care of that, and when is it ever going to end, and they never stop looking for funding. He's right on a lot of that. That's one of the reasons he's such a valuable Member.

But there does appear to be a body of evidence, some of it written about—not in VA writing, but in other medical writings—that in a sense the peeling of the onion has revealed, as Dr. Lipkin was saying, that there is, in fact, to the surprise of many clinicians, a whole second and third layer of trauma which was thought to be either resolved or not there, but which is still there from way back—World War II, the Korean war—as well as Panama, Desert Storm, and others, and obviously, Vietnam.

He challenged the first panel, and I think I wasn't entirely fair to them, because actually a couple of them did want to speak, but their first reaction was to hold back. I wanted to make a point that when you work for the taxpayer, you work for the taxpayer. It doesn't matter whether you're called a Senator or whether you're a psychologist or psychiatrist at a VA hospital. We're all the same, and we all have our obligations to serve and be truthful with our people.

I'd be interested in this panel's reaction to what Senator Simpson had to say, not to put him on the spot or to put you on the spot, but what it was you heard the first panel saying before he entered the room, and how you all feel about that. That's kind of a long-winded question, but you know what I mean.

Mr. GOBER. I want to start it off. First of all, I think the first panel—like I said, when it comes to sitting in on sessions like this, it makes me a better Deputy Secretary, and the first panel can't help but do that. It was time well spent, and I'm glad I was here, and I hope to stay a little after the panels that follow us.

I think that the Senator is right in the respect that I would have hoped it would have been over by this time, too, but it's not. Many of my friends who served in Vietnam—as you know, I just got back from Vietnam, and I found myself with little funny feelings also, revisiting Vietnam after that many years, and they're still out there.

I do know that I have in Arkansas neighbors that I have known all my life that I can remember my mother saying, "Don't mess with him. He's shell-shocked." Well, he didn't have the adequate care, and he's still there. He's still living, and he lives a hermit life. He lost his family years ago. He lives at the end of the road, no electricity, no water, nothing. He bothers no one, but he stays away, and it's part of the fact that he didn't have a Vet Center when he came home.

I'd like to go get him out of his house and take him to a Vet Center, because he's not too old yet. He's about 68. There are a lot of veterans like him out there that are still living like that.

The figures bear it out, too. In 1992 the total number of veterans seen in the Vet Centers was 147,590. Of that, 110,256 were new patients. Now, it's not time to quit. At some point in time we'll reach the point where we say, "No longer do we need those Vet Centers, and we can bring them back into the VA hospital." By that time, we'll all need geriatric care anyway, so we'll have to go back to the hospitals.

But the point is the time is not to stop now. I don't want to see us get almost to the place where we've got a handle on this and give it up. I don't want to see us quit on it yet, because I think we should open it to the combat veterans of Korea and World War

II. If we don't see any, I'll be delighted, because that will prove that they're getting better and they're doing better in society. But I think that we have an obligation to take care of those veterans that need our services, and I'm sure that all of us long for the day when it's over.

It's like so many things the VA does. You know, the VA is a big organization, and change is like pushing a chain or a rope. It's kind of difficult sometimes. But there are little things that happen every day and little bright spots that flare up out there that we shouldn't throw water on, but we ought to give a little more fuel to. I think this is one of those cases.

I can assure you that we have spent many hours this week talking about this issue right here, good conversations, and the VA folks don't hold back on me like they do the honorable Senator. We have good arguments, and we had a good discussion about this, and I think that it cannot help but be productive.

Art, would you like to respond?

Dr. BLANK. I think Mr. Gober has summed up certain of the issues here quite well. I'd like to add a couple of things.

First of all, the provision to open Vet Centers to World War II and Korean combat veterans can be effected at no additional resources. That is not a cost item, and I wouldn't want to leave that uncorrected for the record.

The second point is, if I may be so bold, I'd like to have the opportunity to submit for the record the responses in Stars and Stripes to the article which Senator Simpson inserted in the record.

Chairman ROCKEFELLER. I would welcome that. Send me a copy, will you, please?

Dr. BLANK. Thank you.

[The Stars and Stripes material referred to is retained in the Committee files.]

Dr. BLANK. I'd like to make one other comment about the general theme of the persistence of war trauma. The mind has a marvelous capacity to wait—that is, to wait for opportunities for treatment and assistance. That is simply a fact. We now have good documentation in psychiatric literature of post-traumatic stress disorder coming forth after decades in Korean and World War II veterans. The numbers are not large, which is why we think in the cases of Vet Centers, we will be able to handle those folks without additional resources.

It's important to understand that this is, if you will, a positive phenomenon, because when that happens, as Mr. Gober implied with reference to Elmer, people are able to utilize help and are able to better their lives considerably, are able to reduce the amount of emotional pain and suffering which they have. So this long-time persistence in Vietnam veterans and even more dramatically in Korean and World War II veterans of war trauma is something that's to be regarded as, if you will, a positive and creative phenomenon. People are coming forth in this fashion to be helped, and we're able to help them.

Chairman ROCKEFELLER. Dr. Errera, do you want to comment, sir?

Dr. ERRERA. Yes, I would, Mr. Chairman. I would like to ask Senator Simpson if he feels the same way about chronic cardiac

conditions, chronic arthritic conditions. Does he feel that after a while we shouldn't continue to look after them? I think he would make a distinction and allow them continuing care.

The chronic psychological/psychiatric disorders that we're talking about, as Dr. Blank pointed out, are as chronic as any medical illness. We don't have sufficient capacity to deal with them all. The Vet Centers are an important part of the pool of resources that we have. So I don't think this is a time to cut back in an area where clearly, as much as medical disease, psychiatric diseases need continuing treatment.

Chairman ROCKEFELLER. Thank you.

Can I say, Hershel, that, to be very honest, I was a little disappointed that your official statement submitted for the record is not more positive about my MIRECC's proposal. Of course, this is a matter of how does one choose to read words. I would hope that that is something that you and I might be able to review privately together at a later time. Often one has to use words carefully, and I understand that, but it's something that I would like to discuss.

Let me just ask a final question, and then Senator Akaka is now here, and I need to say that Senator Akaka is the major reason for this hearing. At least the two final panels at this hearing are here because of his leadership and his determination with respect to his bill. Following this panel, as previously agreed, Senator Akaka will chair the panel. I fear that—well, maybe we can bring in some Wendy's. But in any event, we were late in starting, and we understand that, and everybody has been very understanding.

Secretary Goyer, I might just ask you this. Readjustment counseling services, which Senator Akaka cares about so much, have been an enormous help to many troubled veterans, and I would guess that one of the questions that Senator Akaka might have would be the matter of confidentiality. Could I just get you or perhaps Mary Lou to say what it is that the VA currently does to ensure the confidentiality of records for patients in RCS, and do you think that this is handled effectively?

Ms. KEENER. Art and I talked earlier, and they have a policy in the policy manual that specifically references confidentiality of patient records at the Vet Centers. It's my understanding that we've reviewed that and taken a look at it, and that it conforms with our policy regarding disclosure of these records across the board regarding all of our patient records, not only those at the Vet Centers. So the Vet Center policy, as far as we're concerned, is in conformance or should be in conformance with our policy across the board regarding patient records and their disclosure.

As I understand the bill, the bill goes much further than not only our general policy regarding disclosure of records, but it even goes further than a much more restrictive section of title 38 that pertains to the disclosure of records involving patients who are involved in substance abuse, sickle cell anemia, AIDS, that sort of situation.

So we have had some discussions with the drafters of the bill, and it's my understanding that they have indicated to us they're willing to talk with us and work this out, and that perhaps we can come to some agreement so that the bill will not be quite as restrictive in the area of disclosure, because as we see it right now, this

would preclude the VA from being able to look at records in areas of personnel problems, in areas of quality assurance, in areas of program management. So there are some instances in which we feel we would have a need to have access to those records that right now, as the bill is drafted, we're precluded from having access to those records.

So my understanding is that there have been discussions, and there would be no problem in working this out and coming to some resolution of the language as it is currently in the bill draft.

Chairman ROCKEFELLER. Since we're really headed right into your bill, Senator Akaka, maybe this would be a good time for you to chair this hearing, because you may want to respond to Mary Lou and also to carry on with this.

I want to say very clearly to the veterans service groups and everybody else who is here that Dan Akaka——

It's very interesting to me, Hershel. I'm on the Finance Committee, I'm on the Commerce Committee, and I'm on the Veterans' Affairs Committee. I think the Veterans' Affairs Committee is as interesting or more interesting than either of the others, and I think it is so for very, very obvious reasons: One, the fact that we're the largest health care system in the country, we're the largest mental health care system in the country, and the whole world is now revolving around what are we going to do about health care, and we have a very good working health care system; and not only that, but we have other issues which are of great interest.

We have something which is not upon us yet, but, for example, the whole question of the 50th anniversary of the invasion of the Normandy Beach next year—I'm trying to think of Dan Inouye and many, many others, and just how folks who were in their fighting age at that time, how they look at that. I think it's an extraordinary Committee.

Frank Murkowski and I, and I suppose Chairmen and Ranking Members before that, have tried to figure out why is it that people don't show up more. Why is it that Senators don't show up more? It really mystifies me. Frank and I have sent out a letter in which we modestly tried to prod. I am very disturbed by this. I think that people should in part be measured by whether they come to Veterans' Affairs Committees. If they go to Commerce Committees or to Agriculture Committees, why can't they come to Veterans' Affairs Committees? Why can't they do that? Why don't they? I'm very unhappy about it.

On the other hand, if there's somebody that I would never be very unhappy about, it would be Dan Akaka, because he's always here. I think there are a lot of reasons for that, but the point is, he's always here, and I am incredibly grateful to him, just as I am, frankly, that Senator Simpson is very, very often here. Senator Thurmond is very, very often here. There are others on the Democratic side who are often here, but it is not consistent.

It disturbs me. It disturbs me morally, it disturbs me in terms of the Nation's veterans, and it just seems to me something which is not tolerable; and yet, having said that, I haven't been able to effect a change. I'm unhappy about that, and Frank Murkowski and I will continue to work on that.

In any event, I'm very proud to be able to turn this hearing over now to Dan Akaka, who is one of those Senators on our side—the one who is most frequently here, most loyal in his attendance, and, therefore, I really welcome you, sir. I don't want to cut off this panel. It's just that I want to make the adjustment here, because there are questions with respect to your bill which are important.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA (presiding). I want to thank the Chairman very much for his comments. As you can tell, he is a very caring person, and he conveys that very well. I should say that it's good to be in an environment like this where it's cozy—cozy because of the lights. The lights are, I think, extra soft, which I think sets the tone for our hearing today.

I want to welcome panel two and the Secretary for giving up your time and also your thoughts about the bill. From your comments, I feel that you, too, feel that there's a need for this bill. There are two provisions that we need to look at. This is why we're here and we're going to hear from others. But before I get back to you with questions, let me make my statement here.

In particular, Mr. Secretary, besides welcoming you, I want to recognize Steve Molnar, the team leader for the Honolulu Vet Center. He took time out of his vacation to be with us on this occasion. I've known Steve now for a little while, and he was one of the original hires for the Vet Center Program in Hawaii and one of the most dedicated public servants I know. I'm talking about Federal work that's paid by the taxpayers.

I also would like to recognize another familiar face from Hawaii, Susan Angell, who used to head our Vet Center on the Island of Maui and who has testified before this Committee on previous occasions, most notably on the issue of sexual abuse in the military.

I'd like to commend you for holding these hearings, and that's to our Chairman, on VA mental health programs. No area needs greater attention, I feel, than mental health care, whose importance is often misunderstood by the general public. I also would like to thank the Chair for including my bill, S. 1226, the Readjustment Counseling Service Amendments of 1993, on this agenda. I'm pleased to note that Senators Daschle and Inouye are cosponsors of the legislation and that other Members have expressed interest in it, too.

As you know, S. 1226 would make many improvements in the Readjustment Counseling Service, the management entity for VA's 201 community-based Vet Centers. Specifically, my bill would make RCS a permanent statutory service within VA, raise the status of the RCS director, expand eligibility for RCS services, preserve the confidentiality of RCS records, make improvements to the RCS Advisory Committee, expand the Vietnam Veteran Resource Center Program, and establish a pilot program authorizing the provision of primary health care services at Vet Centers. It's all in there. Together these improvements comprise the most comprehensive changes to the program that have been proposed since the Veterans Center Program was created in 1979.

I owe a debt of gratitude to the many, many individuals and organizations—too many to name here—who, out of devotion to the

Vet Center Program and concern for its future, contributed to this bill's formulation. I hope that the Administration and other Members of the Committee will work closely with us to enact this important legislation, and I don't have any question about that.

With gratitude, I look forward to the hearing today and to hearing from the witnesses. I have some questions, and I'll begin with these questions.

Mr. Secretary, on page 3 of your written testimony that section 2 of my bill is—and maybe this is not quite the right word—unnecessary because VA supports the current organizational structure of RCS and would inform Congress of any impending changes, my question to you is, does this mean that the Department accepts the fact that the current structure works very well and that there have been no current discussions to change RCS' organizational structure or to limit its autonomy in any way?

By the way, Mr. Secretary, please feel free to defer to your staff on any question I ask.

Mr. GOBER. Thank you, Senator. Yes, that means that we do not plan to eliminate the Vet Centers. We think the Vet Centers, as they're working now, with the expansion of treating wartime veterans of all periods, would be an improvement, and we have no intent of changing the current mission.

Art, anything you want to add?

Dr. BLANK. No.

Mr. GOBER. In other words, we don't want anybody to be nervous. We have no plans to do anything to it. The Vet Centers, as far as we're concerned, for the near future or the long future, until we get through with the mission, will stay.

Senator AKAKA. As you know, there have been several attempts to restructure RCS. Notably, 2 years ago the Committee obtained copies of internal memoranda, including a memo indicating that VA wanted to place local Vet Centers under the control of the Chiefs of Staff of VA medical centers, in addition, we know that several years earlier VA attempted to close down many Vet Centers or physically relocate them to VA medical centers.

I guess at these different times there were reasons to consider these initiatives, whether it was budgetary or whatever, but I would tell you that I feel nervous, and many others feel the same, that this is such an important part of caring for our veterans that we cannot just leave it that way.

Given the history of attempts to change the administrative structure of the program, are you, Mr. Secretary, or your staff able to guarantee that the next Administration, let's assume 7 years from now, will not also seek to undermine the Vet Centers' independence? My question is, are you able to guarantee that the next Administration will not undermine the Vet Centers' independence?

Mr. GOBER. Well, no, sir. I couldn't guarantee that wouldn't happen, but I can understand that. Let me deal with the change issue first. That's why we favor not putting clinics with the Vet Centers. We think the Vet Centers are a unique organization and that they have been successful. I recall very well working as a veterans advocate in Arkansas when the folks that work at the Vet Centers came to me and got my support to keep from being moved back into the VA hospitals.

We think that the reason they have been successful, as I said in my statement earlier, is the fact that they do not give the appearance of being a medical treatment facility. It's a place where the veterans who are suffering from PTSD can go and feel like they're not in the hospital, where they can talk to counselors that have similar experiences, many of them Vietnam combat veterans.

So I can tell you this: Secretary Brown and I have never discussed anything about changing the organization. I can assure you also that Secretary Brown is very much aware that if he were to have a desire to do something like this, he would talk to the veterans' service organizations and with this Committee and the other Members of Congress who are interested over on the other side of the House. He would not attempt to do something. I can guarantee you that about this current Secretary and his Administration. We realize that we could not be successful in doing that. We're saying that we don't think we really need it, but we're not prepared to fall on our sword over this provision.

Senator AKAKA. In your opinion, Mr. Secretary, is the autonomy that Vet Centers currently enjoy directly related to their ability to carry out their unique mission? If yes, could you speculate as to why there have been attempts to undermine that autonomy in the past, especially since a number of VA reports have indicated that the current Vet Center organization is extremely efficient?

Mr. GOBER. I'll say a couple of words, and then I'll pass it over to Dr. Blank. I only got here in January, so I can't speak to what happened before then, but as I said earlier, we think that the Vet Centers are doing a good job, and Secretary Brown recognizes their importance.

Art, if you'll answer the rest of that—

Dr. BLANK. I think that's an excellent and penetrating question. With regard to the relationship between the organizational structure and the effectiveness of the operation, I think there is a direct relationship. Part of the effectiveness derives from the fact that the staffs of the Vet Centers nationwide consist of over 60 percent theater veterans—served in Vietnam, Korea, or the Persian Gulf. That's absolutely unique within the Department of Veterans Affairs. There is no other organizational element in the Department which has over 60 percent of its staff consisting of war zone veterans.

In my judgment, up to date, at least, it would not be possible to have that kind of staffing, which requires a continuous intensive amount of energy devoted to recruitment and an integrated regional/national organizational structure, whereby our managers in different parts of the country refer candidates for jobs to each other and so on and so forth.

The second thing is that the employment in Vet Centers nationwide does rather well as regards ethnic minority staff. The rates of Asian-American, Hawaiian/Pacific Islander, Hispanic, and African-American staff in Vet Centers are approximately twice the rates that those populations are represented in the underlying Vietnam-era veteran population. That, by the way, derives from policies which were established by the Chief Medical Director—whom, I might say, is the only Chief Medical Director VA has had so far who served in the Vietnam war—policies established by him

and by the program's first director in 1979 to emphasize ethnic minority staffing. Again, the organization is critical to that achievement.

I think the third thing I would mention—there are others, but the third thing I would mention has to do with the overall quality of services which our staff, again nationwide, have managed to achieve in the field. The suicide rate among active Vet Center clients is about 20 percent that of the general population of the comparable age group.

There are numerous other clinical indicators which I think also derive from the ability to centrally, through our regions, direct both the clinical and the administrative aspects of the program.

Having said all of that, as regards the second part of your question—why, then, would anybody want to change this?—I think there are two or three reasons for that. One is, I think while it's true that nothing succeeds like success, it's also true that nothing draws fire like success, and I think it's an inevitable part of organizational life, both in VA and in other large organizations, that when an organization succeeds, it does draw fire for various reasons.

I think another reason is that the program continues to serve as a lightning rod for unresolved feelings in our society about the Vietnam war specifically, and Vietnam veterans remain the major part of our clientele. If you look at the last Presidential campaign, you need look no further to see how unresolved the Vietnam war is a part of our public life, and as a symbol, along with the memorial and some other things, the Vet Center Program, I think, continues to draw some irrational feelings at times because of that.

Senator AKAKA. I'd like to comment that I liked some of the statements you made, Mr. Secretary, that you think all wartime veterans should be included, meaning that we can go back to World War II and the Korean conflict.

Mr. GOBER. Yes, sir.

Senator AKAKA. Also, I liked the statement made by Dr. Blank earlier and was glad to hear the remark that he made that some of these ailments and PTSD problems come to the fore after decades have gone by and that the mind has the ability to keep some of this bottled up until such time as it comes out voluntarily or not whenever services are provided, and also, Dr. Blank, your comment that some of these problems have been taken care of with no additional resources.

My question, Mr. Secretary, is, has the trend of RCS' caseload gone up or down? If up, how has the budget for RCS correlated with this trend? In other words, has the Vet Center budget kept up with the number of client cases, factoring in inflation?

Dr. BLANK. If I may, Senator, the way that question is put exactly, we have not really analyzed, strange as it may seem, the global budget with respect to caseload, and I would like to supply some information for the record on that, if I may. I will say that the cost per visit, which is one way of looking at your question, has not changed from 1982 to 1992. It actually went down \$1, but I think that's an insignificant change. So it may be, as we look at it from other standpoints, that the budget and the caseload remain parallel.

Senator AKAKA. I'm very pleased that VA supports section 3 of my bill to raise the director of RCS to the Assistant Chief Medical Director level. Does VA specifically support the qualifications for that position that are outlined in S. 1226?

Mr. GOBER. Yes, we do.

Senator AKAKA. Are the qualifications, do you feel, adequate? If not, how can they be improved? I guess you do feel it's adequate.

Mr. GOBER. Yes, they're adequate.

Senator AKAKA. If the RCS director position is to be elevated, should VA consider "bumping up" all other RCS employees as well?

Mr. GOBER. I'm sorry, Senator. Will you repeat it, please?

Senator AKAKA. Yes. If the RCS director position is elevated, should VA consider "bumping up" all other RCS employees as well?

Mr. GOBER. That's something we'd have to look at, Senator. I would say that on the ACMD, we would need an additional position within our framework authorization to compliment that.

Senator AKAKA. In your testimony, you indicate support for extending RCS entitlement to World War II and Korean combat veterans. I believe this represents the first time that VA has recognized the fairness of providing all combat veterans, regardless of service period, with access to veterans center services, and I say this to say that I applaud VA's support in this regard.

As you know, one of the wonderful things about the Vet Centers is their ability to respond to new demands in such areas as homelessness, sexual abuse, and disaster assistance. Their flexibility is a tribute to their organizational autonomy and spirit of volunteerism. In other words, Vet Centers have always been involved in helping noncombat veterans and civilians as well. How does this square with what you say in your testimony about preserving the exclusive war zone nature of the program?

Mr. GOBER. Art, you go ahead and try the first.

Dr. BLANK. I think that we see that primarily as a resource question, Senator, that given existing resources, from my view and analysis so far, it's necessary to maintain the entitlement to war zone veterans.

Senator AKAKA. You cite the additional resources needed to provide services to noncombat veterans. How much additional cost are we talking about, if you know?

Dr. BLANK. Our cost estimate for the provision of the bill which would open entitlement in an unrestricted fashion to all veterans is that it would double the present budget.

Senator AKAKA. Is that simply based on the number of eligible veterans, or does it reflect some sort of estimate based on how many veterans would actually seek out Vet Center services?

Dr. BLANK. The latter. It's based on the latter, which, of course, is based on assumptions, since we do not have experience in that area.

Senator AKAKA. I've been told that, like churches, Vet Centers never turn away a veteran who requests assistance. This spirit of caring and helpfulness seems to characterize the program. My question is, are Vet Centers now treating noneligible veterans? If so, how many, and could we possibly conclude that a significant percentage of the cost of providing additional entitlement is, therefore, already assumed in the Vet Center budget?

Dr. BLANK. My view of this—and others, including some of your witnesses today, may have different views. My view of this is that when it is said that Vet Centers never turn away anybody, in order to understand that, one has to make a distinction between providing ongoing counseling, on the one hand, and seeing people for only one or two, perhaps three visits for information and referral. When we say that Vet Centers don't turn away anybody, that includes the fact that a great many people are seen, are dealt with thoughtfully and very helpfully, but in fact are seen only once or twice, and then some other agency or some other part of VA is found to help them.

We do that particularly in the areas where there's no other VA facility. We see veterans from other eras, for one or two visits, perhaps three visits for referral from other eras. I think if there were an entitlement to that created in some unrestricted way, the three-visit limit for nonentitled veterans, which is now a legal matter, would be overcome, and I do think that our present staff would be very hard put to continue to handle in a thoughtful way the numbers of people who would come forth.

Senator AKAKA. I would, then, be concerned about your staff and how much additional caseload RCS can absorb without additional staff. How many additional staff would be needed to cover, do you think, the additional caseload under S. 1226?

Dr. BLANK. With respect to an unrestricted entitlement for all veterans, we think it would require doubling the present staff of 860 or so.

Senator AKAKA. VA supports extending RCS entitlement only to combat veterans. Could you speculate on the Department's position if S. 1226 were modified to simply authorize, as opposed to entitle, Vet Center services for noncombat veterans based on the availability of resources?

Dr. BLANK. I'm not sure what the Department's position would be, but, again, I think that there are so many additional folks that one can handle for evaluation, information, and referral, which I think is the concept that's implied in the authorization—namely, war zone veterans would be given preference for ongoing treatment. Again, I think it would be very difficult for us to handle any significant caseload along those lines.

Senator AKAKA. In your testimony, you support bereavement counseling for the families of those who died of war zone injuries, but not for those who died of service-connected injuries in general, citing in part the availability of resources. How much additional resources would it take to care for the first category as opposed to the second category?

Dr. BLANK. That has not been analyzed, Senator, and I think that will have to be supplied for the record.

Mr. GOBER. Senator, let me say something, going back to your original question, because it ties into this one. You're obviously wanting to do the right thing for veterans and their families. I understand that. I think if you require us—and you so eloquently stated it earlier—if you require us to do something like this, then we have to go in and get extra FTE and extra funds. What I understood you saying in the authorization language is, "If you've got the

time to do it, do it," because that's basically what you're saying. That's the way I understood it.

I think that—and everybody jump in here if I'm wrong, but I see nothing wrong with that concept. If we have additional space or if we have additional time to serve veterans, I know that they wouldn't turn away a bereaved widow, but if you require us to do it, then, of course, we have to take an official position that you've got to give us the FTE and the money to do it, because then people start grading us on it. But if you're going to say, "This is one of those nice-to-do things, if you've got the time to do it and the resources to do it," then, anybody correct me that wants to, but I think that's the right thing to do.

Does anybody disagree?

[No response.]

Mr. GOBER. I think that we would be glad to accept, if it were written that way—don't force us to, because if you do, then we'll have to come back and say you have to give us more money, more resources, but if you're going to say, just as I said earlier, "If you've got the extra resources and you want to do it, be our guest," I'm sure that Secretary Brown would be more than willing to do that.

Senator AKAKA. That will be something that we need to look into. I was trying to gather information as to how much of that or have you been doing some of that.

Mr. GOBER. Well, I know that our people are caring people out there, and they're not going to turn people away. But what it does—and I have also been to these Vet Centers where our counselors are under a great deal of stress themselves, because they're dealing with people that are angry at the system, are angry at everything, and go home and get their guns and come back, and they're not after our people, but they walk in there saying, "I'm going to go kill that so-and-so."

They're in a very stressful situation. They're working with people because they're caring people, and I just don't want to load them down. But we'll be willing to work with your staff on that, Senator.

Senator AKAKA. Moving over to some of the comments that were made by Ms. Keener, I'm very glad that the Department supports the concept of confidentiality of RCS records. I also note that VA would like to work with the Committee in developing language that would give VA more flexibility in the event of litigation or other such contingencies. Are you aware of any research efforts that could possibly breach the wall of confidentiality between VA and RCS?

Ms. KEENER. I'm not aware of any particulars at this time, Senator. I'm sure that if we took a look at it, there are questions involving research and disclosure of records. I'm not aware of any particular instances that might come to mind regarding a breach of disclosure in research, but that, of course, is something that would have to be looked at very carefully. In those contingencies that we're talking about that we would like to work further with the Committee to develop, we'd certainly take that into consideration to make sure that that didn't happen.

Senator AKAKA. Yes, we certainly will want to do that.

Modern health care appears to be moving toward greater emphasis on outpatient care. Having health care services available in 201

already-existing Vet Centers in the community would seem to me to offer VA an opportunity to obtain a competitive advantage in a posthealth care reform environment when VA is expected to compensate for patients against other providers. The question is, is there something in the President's health care plan that would mitigate against the need for Vet Center-based health care?

Mr. GOBER. Senator, I'm not aware of anything in the plan. As you know, we have six Vet Centers right now who have health care outpatient clinics located adjacent to them—four in Hawaii, and one in St. Croix and one in St. Thomas in the Virgin Islands. Our concern with putting outpatient clinics in the Vet Centers—and I'll say a little bit and then let Art jump in and anyone else who wants to, but our concern is that it basically changes the program. We want to keep them separate and distinct from the VA hospital setting.

The six that are functioning now I understand are doing quite well. We just don't think that we need to change the basic mission of the Vet Centers. Also, it would require a major influx of personnel to man those Vet Centers, because we've already got veterans waiting 3 and 4 months to get an appointment in the clinic. We've got people in waiting rooms, sitting there waiting for 4 or 5 hours to see a doctor. So we certainly don't need to take away scarce resources to put them in the Vet Centers. We think that it's working quite well.

Art, do you want to followup on that?

Dr. BLANK. I think probably we all agree with what the Deputy Secretary has said about that, and at the same time I would emphasize that we're all concerned about the availability of health care in the community. I think we all regard this as a very important issue.

Senator AKAKA. There are 201 Vet Centers and hundreds of outpatient clinics. Has there been any discussion in the past about collocating these facilities perhaps after leases for each of the respective facilities run out?

Mr. GOBER. I'm not aware of any. Mr. Hawkins may want to add something to this. The answer to the question is yes, that is a topic of ongoing interest, and I expect that collocations will occur in the future whenever they're feasible.

Dr. BLANK. Are you talking about Vet Centers and outpatient clinics?

Mr. GOBER. Yes. In general, there are competing and different leasing and procurement requirements, however, that are involved with that.

Senator AKAKA. Well, I've really liked your responses and wish we could go on all day, but let me ask, Mr. Secretary, if he has one, what is the Secretary's strategic vision for the future role of the Vet Center Program, particularly as it relates to health care reform?

Mr. GOBER. The Secretary and I haven't discussed this. I guess he would say, though, that he'd have to wait and see what the health care reform finally came out to be. But the Vet Centers serve a unique population, or they should serve a unique population, one unlike anywhere else in the world. They should serve wartime veterans who are having mental illnesses or need counsel-

ing, and they perform a very good function. I think that we would hope that they continue performing their mission until the need for them is no longer there. That means we want to take care of the World War II, Korea, and all wartime veterans.

Senator AKAKA. Well, I want to thank you very much for your responses, Dr. Errera, Mr. Hawkins, Dr. Blank, Ms. Keener, and Secretary Gober. Thank you so much. Your comments will certainly be helpful in structuring that bill. Thank you very much.

Our third panel consists of representatives from veterans' organizations: John Vitikacs, Assistant Director of the National Veterans Affairs Rehabilitative Commission, The American Legion; Dave Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; Terry Grandison, Associate Legislative Director, Paralyzed Veterans of America; and Jim Magill, Legislative Director, Veterans of Foreign Wars.

Welcome to this hearing. We appreciate your presence, and your testimonies will be included in the record in their entirety.

May I ask that we begin with John.

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. VITIKACS. Good afternoon, Mr. Chairman, Members of the Committee. The American Legion appreciates the opportunity to present its views on the various subjects under consideration today and for the continuing efforts this Committee makes in seeking to improve VA's health care programs. The Legion looks forward to working with the Committee in the coming months in helping to shape and carry out VA's role in the upcoming national health care reform initiative and in developing an appropriate VA health care eligibility reform proposal.

Mr. Chairman, for the sake of brevity, I will limit my oral summary this morning to S. 1226 and request that the rest of our statement be included for the record.

Senator AKAKA. Without objection, your prepared statement will appear in the record.

Mr. VITIKACS. Mr. Chairman, The American Legion commends you for having the vision and the courage to introduce legislation which would move VA away from traditional thinking on the structure and makeup of the Readjustment Counseling Service Vet Center Program. The Readjustment Counseling Service has been a dynamic force in addressing the most pressing issues facing the veteran population it serves. While the primary goal of the Vet Center Program is to provide psychological counseling to assist wartime veterans' readjustment to civilian life, it has been active in other areas.

With qualification, the Legion supports the provision of S. 1226 which calls for expanding Readjustment Counseling Service eligibility to all veterans. In our view, psychological counseling services, along with the full range of Vet Center services, should continue to be an entitlement for wartime veterans, as defined by the Congress. We must ensure that the resources of RCS remain a priority for wartime veterans' readjustment needs.

We support the notion that all veterans should be eligible to access informational assistance and referral services offered by Vet Centers. The Vet Centers currently serve all veterans who seek basic benefits information. By expanding benefits assistance eligibility to all veterans, Vet Centers would simply formalize their current practice. We caution, however, that a change in eligibility and a resultant increase in workload may require some new staff and resources.

The Advisory Committee on the Readjustment of Vietnam and Other War Veterans is the chief advisory body to the Secretary on readjustment issues. Because the committee is comprised of non-VA members, it represents a point of view independent from the Department. The Legion believes it is important to permanently authorize this committee's advisory role by statute. In our opinion, the proposed renaming of the committee to the Advisory Committee on Veterans Readjustment would reflect the proposed expanded mission and mission change of the Readjustment Counseling Service.

With regard to the proposal for VA to submit a plan with an implementation schedule for the expansion of the Vietnam Resource Center Program to all Vet Centers, the Legion supports the idea of undertaking a feasibility study to determine the practical benefits of this proposal. The VVRC Program has enjoyed considerable success, as documented by VA's own findings. We support the continuation of the existing 10 VVRCs, with consideration of expansion to additional centers.

Any such expansion is a resource-dependent proposal and should be explored in relation to large population areas. In all instances, nonwartime veterans seeking the full range of Vet Center services should be provided relevant VA benefits information and/or be connected to local or State referral sources.

The Legion supports the proposal to establish a 2-year pilot program to test the practicality of offering limited health care services through RCS Vet Centers. The scope of services and anticipated workload in carrying out this program would certainly be lower than in traditional outpatient clinic sites. Additionally, VA would have to be very careful in selecting sites for this pilot program, as not all Vet Centers have adequate space for such a project.

The American Legion believes that this proposal has merit in reaching new veteran beneficiaries and would significantly improve veterans' access to primary outpatient care. In the event the national health care reform takes place, this concept could be a valuable VA marketing agent.

Mr. Chairman, that concludes our statement.

[The prepared statement of Mr. Vitikacs appears on p. 105.]

Senator AKAKA. Thank you very much, Mr. Vitikacs.

May we hear from David Gorman, please?

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman. It's a pleasure to be here and appear before the Committee this afternoon.

I would state initially, Mr. Chairman, the DAV's general support for your measure, S. 1226, and its intent of strengthening and expanding the scope and services provided by the Readjustment Counseling Service and its nationwide system of Vet Centers.

I was struck, Mr. Chairman, by your statement when introducing S. 1226, and it bears reciting, if I may at this time, and that is that the Vet Center Program is well worth preserving. You said that it is a national resource that has proven its worth many times over since its establishment 15 years ago. Mr. Chairman, those few simple words very aptly, in our opinion, describe the valuable program and national resource operated by the many dedicated and committed VA employees who make it function for the betterment of veterans and their families on a daily basis.

Having made that statement, we are, however, somewhat concerned, Mr. Chairman, that should the provisions of section 2 become law, then the continued existence of Vet Centers may very well be jeopardized to the extent the program may not be able to effectively function. While it is not our intent to suggest Vet Centers be under the strict unilateral control of medical center directors, we do believe that to statutorily mandate a total segregation from the mainstream VA health care delivery system, however well intentioned, could prove to have the opposite effect of that contemplated by section 2.

Mr. Chairman, section 8 proposes a 2-year pilot program to determine the feasibility of offering health care services at readjustment counseling centers. It is our sincere belief that the concept of providing certain health care services to eligible veterans at Vet Centers is long overdue. Unquestionably, such a program can only serve to have a positive effect on veterans and their health status.

In addition to the fully defined psychological needs of veterans seeking services at Vet Centers, it would seem that their existing physical disabilities will require the seeking out of medical care at some point. As Vietnam veterans age, it will be inevitable that the presence of additional disability and disease will manifest, and we can envision Vet Centers playing a significant role in the early detection and treatment of additional disabilities by means of having VA health care personnel physically located at Vet Centers.

We are, Mr. Chairman, therefore, totally supportive of such a concept being implemented, where appropriate, in Vet Centers. I would say also that we are supportive of the other provisions of your measure, Mr. Chairman.

Mr. Chairman, the DAV is also pleased to state our support for the proposed legislation that would create Mental Illness Research, Education, and Clinical Centers. We would suggest, however, that perhaps language should be added dealing with a peer review process to be included in both the site selection process as well as the various research proposals that will inevitably come from the MIRECCs.

Mr. Chairman, it is our belief that the VA does a good job in providing mental health care; however, we believe the potential exists for VA to do significantly more. VA needs to develop a commitment and a system-wide focus, with standards for the treatment of chronic mentally ill veterans via a continuum of services, to include

alternatives to inpatient hospital care. Many wonderful programs exist, but in a largely uncoordinated manner.

Mr. Chairman, there is a significant potential for the successful treatment and rehabilitation of veterans with psychiatric disorders. To do so, however, will require a dedicated system of care that is well organized, well managed, and coordinated. Such a system must be able and willing to offer a full spectrum of comprehensive, nontraditional, and alternative modes of care, stressing reentry into the community and, ultimately, independent, self-sustained living.

Mr. Chairman, that concludes my oral testimony. I'd be glad to attempt to respond to any questions you may have.

[The prepared statement of Mr. Gorman appears on p. 109.]

Senator AKAKA. Thank you very much, Mr. Gorman.

Mr. Grandison.

STATEMENT OF TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. GRANDISON. Mr. Chairman, Members of the Committee, good afternoon. Mr. Chairman, the VA has made commendable first steps toward increasing noninstitutional methods of care for the chronically mentally ill. For example, the Homeless Chronically Mentally Ill Program was begun in 1987, and since that time the VA has had contact with approximately 10,000 veterans per year.

VA estimates that from one-third to one-half of the Nation's homeless are veterans, and the number of homeless veterans could be as high as 250,000. Moreover, two-thirds of that number are likely to be drug- or alcohol-addicted. VA also states that up to 45 percent of those enrolled in this program have serious medical conditions.

Veterans who need psychiatric and medical care are aided through VA clinics and community-provided rehabilitative services. Even more spectacular is the success of the post-traumatic stress disorder program for which the Congress has also been heavily committed through specified incremental appropriations. The National Vietnam Veterans Readjustment Study claims that approximately 500,000 Vietnam-era veterans need treatment for this disorder.

The noninstitutional options such as these could be repeated for other types of mental illness. Unfortunately, because of the perversity of current entitlement rules, the majority of the core group veterans cannot be offered outpatient care. As a result, they are either provided more expensive hospitalization or, more often, denied access to VA care altogether. This is but one glaring example of the need for eligibility reform.

While the VA has made a start in shifting to noninstitutional modes of care, it is far short of what is required if it is to earn a place in tomorrow's competitive medical market. To meet acceptable standards of efficient and economic delivery of care, much more emphasis, including capital investment, needs to be placed on ambulatory programs for the chronically mentally ill veteran. Therefore, PVA recommends the following:

First, enact veterans eligibility reform to mandate full continuity of care, with special emphasis on expanded outpatient care for all

core group veterans; two, provide incremental appropriations for expansion of VA plant facilities designed for ambulatory medical programs; three, provide the staffing and resource enhancements for 30 existing long-term psychiatric care facilities; four, provide 150 additional homes for therapeutic residencies for veterans in these programs and provide these programs as joint ventures with nonprofit entities; five, VA should expand its nationally recognized expertise in geriatric medicine by supporting residencies and fellowships in no fewer than 10 VA medical centers.

At this time, Mr. Chairman, PVA would like to state for the record that we do support Senator Rockefeller's Mental Illness Research, Education, and Clinical Centers draft legislation. In addition, Mr. Chairman, PVA supports your bill, S. 1226, the Readjustment Counseling Service Amendments of 1993.

For the sake of time, Mr. Chairman, I would just like to include PVA's recommendations to your legislation, and there are two. First, medical centers providing the Vet Center ambulatory care teams should be given additional funding to support this activity. One of the reasons VA has been unable to expand its outpatient base is that annual appropriations are falling short of the necessary level to support increases in outpatient demand.

Two, the selection process that will identify which Vet Centers are to be chosen for the pilot program should ensure that these additional activities will not detract from the mission or the ability of the individual Vet Center to perform its original mandated function.

Mr. Chairman, thank you for this opportunity to express our views. I will be happy to respond to any questions that you may have. Thank you.

[The prepared statement of Mr. Grandison appears on p. 112.]

Senator AKAHA. Thank you very much, Mr. Grandison.

Mr. Magill.

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MAGILL. Thank you, sir. The first portion of my statement was devoted to oversight, and I will just summarize that, and then talk about the two bills before us today.

VFW believes VA has made great strides in its treatment programs of the chronically mentally ill. Its research role in the treatment is highly respected and considered essential by experts in the field. In fact, the VA's research capability is so well regarded that the National Institutes of Health contribute financially and materially to its efforts.

Considering the resources VA has been provided, we believe they are doing a good job. However, it has to be noted that considering the workload facing VA, they are still underfunded and understaffed.

In our letter of invitation, it was requested that we comment on two legislative proposals. S. 1226, introduced by you, would amend title 38 to provide for the organization and administration of the Readjustment Counseling Service, as well as to improve eligibility for readjustment counseling. The VFW has recognized the crucial role of the Vet Centers and how they have played in returning vet-

erans to the mainstream of society. While originally conceived as a program exclusively for Vietnam veterans, its value has been recognized to the point where it now serves veterans of other conflicts as well. The VFW does support the provisions of S. 1226 and encourages its enactment into law.

We were also asked to comment on a draft proposal introduced by the Chairman of the Committee that would require the establishment of Mental Illness Research, Education, and Clinical Centers within the Department of Veterans Affairs. The VFW believes the draft proposal introduced by the Chairman is an excellent step in enhancing VA's ability to care for the chronically mentally ill. While the VFW supports the thrust of this proposal, we do not believe that clinical and scientific investigation activities should be in competition with other research programs for funding dollars. We also have concerns with granting of priority of one research program over another when competing for funds.

This concludes my statement. I'll be happy to answer any questions you have.

[The prepared statement of Mr. Magill appears on p. 115.]

Senator AKAKA. Thank you very much for your statement.

I want to thank all of you on this panel for your strong expressions of support for S. 1226. I hope that we can work together, and I don't see any problem with that, to alleviate concerns that others may have about this measure.

Mr. Gorman, in your statement, you indicated your concerns that section 2 of my bill could have the effect of isolating RCS from the mainstream VA health care delivery system. I would point out that this provision merely codifies the situation that already exists. Numerous studies and reports indicate that one of the basic strengths of RCS is its organizational structure. This being the case, are you in effect implying that the current structure is detrimental to RCS?

Mr. GORMAN. Mr. Chairman, in presenting our testimony and developing the position we have, we looked not necessarily toward tomorrow or perhaps even next year, but well into the future, and I think really what Senator Simpson was saying this morning, I think that's an argument that, No. 1, the DAV does not believe or does not buy into. But I think it's one that could be a persuasive to many who don't know what VA is to the health care delivery and, more particularly, what RCS is and what it does.

I think in order to maintain RCS, it's our belief that to strengthen that ability, it's going to be necessary in the world of health care reform and in the world of where the VA is going to be going in the future for health care reform, there's going to have to be, in some fashion, a cohesive unit delivering health care services. For example, in the VA's testimony, I think they're somewhat contradictory in opposing the idea of a pilot program because of a change of the mission of what the Vet Centers would be, while at the same time acknowledging readily the trend in health care is to get away from the institution and out into the community and ambulatory care setting.

I think simply the Vet Centers that are there should remain there, with the primary focus of providing readjustment counseling services to wartime and combat veterans. However, without diminishing that mission, we believe that there's going to be a need and

an opportunity to in fact broaden that mission, expand that mission, while still maintaining the original intent and flavor of RCS.

Senator AKAKA. Mr. Magill, you indicated a belief that VA should develop innovative psychiatric care programs in less restrictive settings and also expedite veterans' return to the community. You also expressed concern for further development of programs for the homeless and for substance abuse as they relate to mentally ill. Finally, you expressed the fear that veterans may be being released from VA medical facilities without adequate support facilities.

Given that the veteran centers are a much less restrictive environment, that they already have outreach programs dealing with homeless veterans and substance abuse, and that they are recognized experts in the field of providing support group counseling, would you agree that Vet Centers can play a vital part in addressing some of the more pressing issues that you have cited?

Mr. MAGILL. Yes, I would agree with that. My comments were based on reports that we have heard from veterans coming out of institutions. Of course, when you are under a controlled environment, you do have somebody to make sure that medication is taken at a specific time during the day. It's quite possible that veterans need to be coached, if that's a good word to use, when they go out to utilize the various Vet Centers that are around. Again, I think that they can play a very crucial role in getting the veteran back into the mainstream of society.

Senator AKAKA. Mr. Grandison, you urged that the selection process used to choose health care pilot program sites should ensure that these activities do not detract from the mission of the individual Vet Center. Would you elaborate on your concerns in this matter? For example, do you think that control of all on-site personnel should be directed by the Vet Center team leader?

Mr. GRANDISON. Mr. Chairman, first of all, I think that the record magnifies or the history of the Vet Center success magnifies that they have worked, and your attempt to codify this particular service is a great step forward. However, when you impose a pilot program, you have to make sure that its primary mission is not in any way detracted or diminished.

So that's our concern. We want to make sure that the Vet Center is still able to do its primary mission—to treat the veterans that use their facilities—but at the same time be able to execute the pilot program successfully.

So that's our main concern, that both can operate mutually and not with friction or any type of conflicts in its mission.

Second, I think the independence of the Vet Center and the freedom from the bureaucracy and the feeling of being unfettered by the administration of health services or by any other problem I think has to be maintained. Therefore, I think team leaders should control on-site personnel at the Vet Centers and that necessarily goes to the original concept behind the Vet Centers.

PVA can support this concept as long as the operation of Vet Centers are done in a fluid way, and there's no disruption of the existing services and all services are utilized in a way that accomplishes its main goal, which is to treat the veterans. We don't want to enact a redundancy, and we don't want to enact or codify a bureaucracy. So with those caveats, we can support it.

Senator AKAKA. Mr. Vitikacs, in the Legion's analysis of the VVRC pilot program, you pointed out that in all cases the augmented staff positions and funding would generate entirely from internal redistribution of existing RCS resources. Do you think that given that VVRCs could well be expected to tighten the caseload of the regional benefits offices, the resources for expansion of the VVRC Program might be successfully redistributed from these areas without the need for additional resources?

Mr. VITIKACS. I would just like to say first off, Senator, Mr. Chairman, that the information that all of the augmented staff positions for the 10 VVRCs being secured from internal redistribution was information that I obtained from a VA report.

To answer your specific question, there is an available computer linkup between Vet Centers and with the regional offices, the veterans benefits regional offices. Under the original 10 VVRC pilot programs, which VA has maintained, there was an extensive liaison and reciprocal referral activities with local VA regional office staff. There was training of Vet Center staff by the regional office staff. The regional office staff also provided periodic site visits to the Vet Center locations for counseling purposes.

If we are discussing here today the idea of having medical services either on a periodic basis or a full-time basis at Vet Center locations, I would think that the notion of having periodic site visits scheduled at Vet Centers by regional office benefits counselors would also be something that we would consider.

So if the idea, as presented in the bill, would require additional resources, we believe that it would be minimal. It's very feasible and very practical to pursue this idea.

Senator AKAKA. Well, I thank this panel very much for your testimonies. No question that it will be helpful to us in our work here, and I thank you very much for coming.

Senator AKAKA. Our fourth panel consists of personnel from VA's Vet Centers. We have with us Dr. Al Batres, Chief Clinical Manager, Western Region; Dr. Joe Gelsomino, Chief Clinical Manager, Eastern Region; Dr. Susan Angell, Regional Manager, Pacific Western Region; and Dr. Bill Weitz, team leader, Palm Beach Veterans Center.

All the witnesses have submitted program summaries, which will be made part of the record. Please limit your own remarks to 5 minutes.

Let's begin with Al.

STATEMENT OF DR. ALFONSO R. BATRES, REGIONAL MANAGER, READJUSTMENT COUNSELING SERVICE, WESTERN MOUNTAIN REGION 4A, DENVER VET CENTER, AND CHIEF CLINICAL MANAGER—WEST

Dr. BATRES. Thank you, Senator. [Remarks given in Native language.] Hawaii No Ka Oi.

Mr. Chairman and Members of the Committee, it's truly a pleasure to have the opportunity to be here to brief the Members of the Committee on the activities of the Readjustment Counseling Service. I want to start by letting you know that my father was a World War II veteran who served in North Africa, I'm a disabled Vietnam

theater veteran, and my son Alfonso was an airborne scout with the 82nd Airborne, who served in Operation Desert Storm.

The mission at Readjustment Counseling Service is to lead a high-quality and accountable administrative and clinical system of regional Vet Centers to provide readjustment counseling services to Vietnam-era veterans, veterans of conflicts in Lebanon, Grenada, and Panama, veterans of the Persian Gulf, and women veterans who were sexually traumatized during military service, as well as to ensure that each Vet Center maintains high-quality clinical and administrative standards in compliance with RCS and Department of Veterans Affairs policy.

One of the points I wanted to make is that in addition to post-traumatic stress disorder, Readjustment Counseling provides a variety of other readjustment services, and it is not exclusively focused on providing PTSD services to veterans.

The Western Mountain Region that I manage has the largest geographical area of the seven readjustment counseling regions. The region encompasses a 10-State area reaching from New Mexico to Alaska and employs 105 full-time employees, which have been augmented by 4.3 full-time FTEE, to outreach for veterans of Operation Desert Storm, and an additional four FTEE to outreach and counsel women veterans suffering from the effects of sexual harassment and assault during their military service.

My region includes 26 Vet Centers and 34 community mental health providers under contract, providing services at 59 community locations. Many of our Vet Centers are located in rural areas, such Missoula, Montana, and Fairbanks, Alaska, often representing the only Department of Veterans Affairs presence in these communities. Due to its large geographical area, the Western Mountain Region must focus on the delivery of services to rural, hard-to-reach populations. Our employees use a variety of outreach techniques to serve these widely dispersed populations.

Some examples of these outreach methods are the annual attendance by our Vet Centers in the Pacific Northwest, that is Seattle, Spokane, and Tacoma, Washington at Camp Chaparral on the Yakima Indian Reservation, an outstationing of a woman sexual trauma counselor from the Boise, Idaho Vet Center at the local YWCA, and the work of the Casper, Wyoming Vet Center with the Central Wyoming Rescue Mission in providing assistance to homeless veterans.

One particular project which I would like to focus your attention on is our one-person Vet Center outstation on the Hopi Indian Reservation in northern Arizona. Mr. Cliff Balenquah, counselor on the Reservation, will later provide some insight into this special outreach effort.

In addition, RCS has formed a Rural Working Group, a new national working group, the operation of which I oversee, to study the unique characteristics of service delivery to disperse rural populations utilizing limited resources. Mr. Mike Loy, team leader of the Reno, Nevada Vet Center, is the chairman of the Rural Working Group and will provide testimony regarding the general delivery of services to rural areas.

Thank you.

[The prepared statement of Dr. Batres appears on p. 117.]

Senator AKAKA. Thank you very much for your statement. Next we'll have Dr. Gelsomino.

STATEMENT OF DR. JOE GELSOMINO, REGIONAL MANAGER, SOUTHEAST REGION, READJUSTMENT COUNSELING SERVICE, BAY PINES, FLORIDA

Dr. GELSOMINO. Thank you very much. Thank you for the opportunity to speak to you today. I would like to describe the services provided by Vet Centers in the southeastern United States and beyond.

The Readjustment Counseling Service provides a variety of services aimed at assisting veterans of the Vietnam era and post-Vietnam era who are having difficulty adjusting to civilian life as a result of their military experience. The southeastern RCS region consists of 25 Vet Centers and two satellite centers within the following locations: Mississippi, Alabama, Florida, Georgia, North Carolina, South Carolina, Puerto Rico, and the Virgin Islands.

Vet Centers see many veterans who exhibit symptoms of post-traumatic stress disorder resulting from trauma incurred while serving in the military. Because the effects of trauma are often delayed, a veteran may not associate it with being in the military. By the time an affected veteran is seen at Vet Centers, he or she most likely will have experienced many of the classic symptoms of PTSD. The veteran may be chronically unemployed, have had multiple marriages, numerous psychiatric hospitalizations, or other personal problems, such as rage and impulse control, hypervigilance, extreme guilt, which may or may not include substance abuse.

The Vet Centers provide a range of services, to include problem assessment and counseling and psychotherapy, to veterans and their families. We also assist with concrete needs, such as food and shelter for homeless veterans. Recently, we have added services for women veterans who have been traumatized as a result of sexual abuse experienced while in the military.

Rural veterans who often cannot access readjustment services due to living in areas distant from VA facilities are provided services through our Fee Contract Program, a network of private sector therapists under VA contract. Vet centers provide outreach to veterans who may not know of the services to which they are entitled. Vet center staff often visit places veterans frequent and provide services in clinically nontraditional settings in the community.

When the needs of the veteran are beyond the scope of readjustment counseling, they are referred and linked to other VA or community resources. The Vet Center staff have collaborative relationships with clinical services at VA medical centers and outpatient clinics. Reciprocal referrals with VA substance abuse, stress recovery units, and other psychiatric services are ongoing.

I'll be happy to answer any questions you may have at any time. [The prepared statement of Dr. Gelsomino appears on p. 118.]

Senator AKAKA. Thank you very much.
Susan.

**STATEMENT OF DR. SUSAN A. ANGELL, REGIONAL MANAGER,
READJUSTMENT COUNSELING SERVICE, PACIFIC WESTERN
REGION, SAN FRANCISCO, CALIFORNIA**

Dr. ANGELL. Aloha, Senator Akaka. I wish to start by expressing my appreciation for your work in support of our veterans, as evidenced by this bill S. 1226, and your most gracious and eloquent introduction of this bill. It's my honor to participate at this hearing today, and I thank you for the opportunity to do so. I'm currently the Regional Manager for the Readjustment Counseling Service's Pacific Western Region. As regional manager, I am responsible for the clinical and administrative functions of 31 Vet Centers located in California, Oregon, Hawaii, and the Territory of Guam. My duties also include the oversight of the Asian-American/Pacific Islander Working Group membership. I am also on the VA's Task Force on Sexual Trauma, and I am chairing the Readjustment Counseling Service's Transition Committee for Sexual Trauma Counseling.

I have six Vet Centers in the Pacific Western Region that have been assigned additional staff to specifically outreach the Persian Gulf veterans. Since eligibility was expanded, the region has outreached and serviced over 9,620 Persian Gulf veterans and their families. Eight of the Vet Centers in the Pacific Western Region have been assigned staff to outreach and treat women veterans who have experienced sexual trauma while on active duty. The Pacific Western Region designed and implemented a survey which was used nationwide in the Readjustment Counseling Service and brought to light the proclivity of sexual trauma within the female clientele currently being seen at Vet Centers. Our regional office and numerous of our Vet Centers have been utilized as training and orientation centers for international efforts by the countries of El Salvador, Australia, and Russia to address their veterans' PTSD treatment needs. This would indicate international respect and recognition for the success of the Vet Center Program.

In addition, our region has spearheaded the VA response to disasters, such as the Loma Prieta earthquake, the Oakland firestorm, Hurricane Iniki on Kauai, and Typhoon Omar on Guam, and also our response to the Los Angeles riots. During these disasters, RCS was often the first on the scene mobilizing counseling resources, outreaching to traumatized individuals, and providing crisis debriefing as needed to individuals and other health care providers.

In summary, Senator, Vet Centers remain on the front lines of the treatment of PTSD and have proven to be a user-friendly mode of access to the larger VA system of care available to veterans.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Angell appears on p. 119.]

Senator AKAKA. Thank you very much, Dr. Angell.

Dr. Bill Weitz.

**STATEMENT OF DR. WILLIAM A. WEITZ, TEAM LEADER, READ-
JUSTMENT COUNSELING SERVICE, PALM BEACH, FLORIDA
VET CENTER**

Dr. WEITZ. Thank you very much, Senator, and I want to express my appreciation to yourself and Senator Rockefeller for not only

holding hearings on the valuable RCS and Vet Center Program, but also for the opportunity to have people who are directly in the field and have direct hands-on clinical involvement with clients—people like myself—present information to your Committee.

Let me say that currently I am the team leader of the Palm Beach Vet Center, which is located in Lake Worth, Florida. It is largely a suburban environment, but, interestingly, many of our veteran population in this area live a rural existence, so it's a combined rural/suburban environment, as opposed to a large city. We are an expansion facility, established in 1985, during the third major RCS evolution.

Currently, our Vet Center handles a caseload of approximately from 75 to 80 client visits a week. We meet the productivity requirements in terms of new clients, client visits, and we are able to stay within the program guidelines that are set for teams in terms of outreach, networking, and referral and consultation functions.

My center, because I am a clinical psychologist and the credentials of the staff that I've hired, is a very clinically-based center. That is, the professional education and training of staff allows us to focus very intensely on diagnosis, treatment, and clinical counseling. Although we certainly provide outreach and networking and referral types of functions, many of our clients are in direct clinical services, to include individual, peer group, marital, and family counseling.

We additionally have had the opportunity, through utilization of external resources like Department of Labor DVOPs, individuals, and volunteer DAV benefits and claims counselors to offer claims and benefits services, to offer employment counseling and placement, and referral assistance. Thus we try to supplement the basic clinical functions of Vet Centers through the appropriate utilization of external staffing.

I want to say also, before my taking the position in Palm Beach, I was initially a Vet Center staffer back in 1979. I was one of the original team leaders. I had the privilege of opening, with Max Cleland in attendance, the Vet Center in Miami. I must say that that was quite an exciting time for me, coming directly out of the U.S. Army. I perceived at that time that it was a very interesting program, because no one really expected Vet Centers to exist for longer than 2 or 3 years. We were set up to fail.

We had largely new employees to the VA, strangers to one another, put in community environments, with very little input in terms of program guidelines and training manuals, set up in store fronts to deal with large numbers of veterans that we were told were very angry, hostile, isolated, and estranged from the Government. We were to represent the Government, and, of course, there would be security guards or other safety precautions.

I would suggest, therefore, that in examining the very existence of this program today, one might explore some of the program's success factors. I would advise the following: one, a tremendous commitment and dedication by staff, with a tremendous ability to be innovative, to take chances and risks, and to do what is required to help the veterans; second, the utilization of a psychosocial model, not a medical model—a model which would not have been possible

had we moved into hospitals or clinic facilities; and, third, the clear belief that this is not a giveaway program by the United States Government to the veterans of our Nation. This is essentially an innovative, prepaid health program based on the fact veterans have earned the rights to health care services through utilization of Vet Centers by virtue of their service to their country.

It is indeed unfortunate that the perception of many veterans that come to my facility is that they are not entitled to the same health care privileges that illegal immigrants may have upon access to this country.

I welcome the opportunity to present my input to you and would be pleased to answer any questions as appropriate.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Weitz appears on p. 119.]

Senator AKAKA. I thank all of you for your testimony.

Before I start with the questions, in the interest of time, I'll ask you to please feel free to not answer a question if you feel that a satisfactory answer has been provided by a fellow panel member. What I'm going to do is ask a question and have all of you answer, if you want to.

At the outset, could you briefly tell me a little about yourself and how you came to work in the Vet Center Program?

We could start from Dr. Batres again.

Dr. BATRES. Thank you, Senator. I came into the Readjustment Counseling Service from a university setting. I was teaching at the University of Colorado and was intrigued by the Vet Center system, since I'm a strong believer in community-based programs. Having been a Vietnam veteran myself, I was attracted to the Vet Center Program and its mission, specifically.

Since then, I've come to really appreciate something that I think Senator Rockefeller was alluding to before. The motivation to work in the Vet Center is not driven by external incentive, and I don't think any amount of compensation alone would be enough to draw me to do this work. My motivation in fact is an internal incentive. It's my commitment to do a job the best that I can to help veterans in a growth-producing manner, and that's what motivates, I believe, myself and many of my colleagues to do the type of work that we do.

Senator AKAKA. Dr. Gelsomino.

Dr. GELSOMINO. I served in Vietnam in 1969 and, subsequent to that service, went on and worked on a Doctorate in counseling psychology. As part of that training, I spent a year as an intern at a VA medical center in Buffalo, New York, which was my first real exposure to the kinds of problems some of the Vietnam veterans were having and, at that point in time, decided that once I completed my Doctorate, I wanted to work for the VA, which I did.

I eventually went on and became a psychologist in the mental hygiene clinic at the VA medical center in Wilmington, Delaware. During that time, I really began to work not only with Vietnam veterans, but there were a lot of World War II veterans and Korean veterans coming into the medical center and into the mental hygiene clinic, and it struck me that I was seeing World War II veterans some 30 years later who were still experiencing flashbacks, intrusive memories, and still having a lot of problems.

I was struck by the fact that for years the group they were involved in was advising them that they needed to sweep it under the carpet, that that was the way to deal with it, and that this had really been the advice of the therapist, but I think it was based on some lack of knowledge of what needed to be done at that point in time.

When the Vet Centers were put into existence in 1979, I saw this as a real opportunity to address an unmet need and jumped at the opportunity and became the team leader of the St. Petersburg Vet Center and eventually became the regional coordinator for the region.

Senator AKAKA. Dr. Angell.

Dr. ANGELL. Well, Senator, my career with the VA and really with the Vet Center kind of had a rebellious start to it. In 1979 I was walking down Kapiolani Boulevard and ran into the original Vet Center that Mr. Molnar was the team leader for, and since I was a social work student at the time, I thought, "What a wonderful resource for our veterans, particularly our Vietnam combat veterans." I shared that experience and that discovery with some of the people that I worked with, and the advice on their part was to stay away, that these were dangerous people, that they had no part in the VA long-term, and that they would be gone in 2 years.

That really cemented my commitment to the program. It was a program I wanted to be a part of, it was a population that I felt very committed to, it was the war of my generation, and from that point on, both in finishing up my social work program and in the papers that I wrote, everything that I did related to PTSD and Vietnam veterans.

It took me several years to be hired into the Vet Center, and I was always knocking on their door every time a position was open. I started out as a volunteer and then as a contractor. Finally the doors opened and I was hired as a social worker. I have been with RCS ever since and am very proud to be a part of the Vet Center program.

Senator AKAKA. Dr. Weitz.

Dr. WEITZ. Thank you. Interestingly, the Vietnam war had, in many ways, a profound effect on where I sit today professionally and career-wise. At the time of my initial entry into graduate school in psychology, I envisioned myself as working in the private sector, basically generating large dollars to provide private sector services. However, with the abolishment of the draft and need to make choices, I took a look at the opportunity to enter a U.S. Army health care scholarship program, which I did enter, and was directly commissioned as an officer in the military, with, of course, the requirement of providing payback services.

Following completion of my degree in psychology, I, in fact, provided those services, and surprisingly, I found that I liked the military as I enjoyed providing the kinds of care and opportunities for treatment and diagnostic work and the kind of creativity that was allowed for relatively young officers. After an 11-year period of working in Army hospitals and clinics, I made the choice of leaving military service to move into the private sector. That was in 1979, the same year that the Vet Center bill was passed.

I was approached by VA personnel who were tasked with essentially finding trained and credible staff. Because of my prior military experience and my degree in psychology, they asked me about the opportunity of working for the Department of Veterans Affairs. I had never considered that option. I had always seen myself as not functioning well within traditional settings. I did, though, consider this opportunity for many reasons, but one of the most significant is that this option gave me an opportunity, along with the staff, to build something from the beginning. There would be no one else to blame in case of failure or in case of problems, no one to look back on and say, "If they had only not done such and such." We were starting from the ground up.

It was a real opportunity to initiate something and build and develop a program that we all felt could be successful and were very committed to. In fact, that is what drove me initially to the Vet Center Program. After a 3-year period, I must confess, I left the program as a function of burnout, but also for the opportunity of taking a position in Hawaii at Tripler Army Medical Center, which the Army offered me, so I hope you'll excuse me for that, for serving on the great island of Hawaii for 3 years. I came back to my senses, reentered the Vet Center Program in 1985, and have remained there to the present day.

Again, I say that, in many ways, 25 years working for the Department of Veterans Affairs and the Department of Defense was not in my original career plans. I've enjoyed the work tremendously, largely as a result of not only the clients that we serve, but the tremendous staff and the people that I work with.

Senator AKAKA. Thank you very much. As I said, I'll pose the question, and all of you or none of you may want to answer it.

Critics have pointed out that RCS was supposed to be a temporary program for Vietnam veterans, but that it has been expanded into something that was never intended by the original authors. Would you comment on this?

Dr. GELSOMINO. Well, I think that's probably a very accurate statement in terms of it's certainly turned into something it was never intended to be. As one of the early team leaders, it was real clear that the initial message about what the Vet Centers were about was to go out and reach the veterans in the community, for the most part, although there were areas where things were a little more heavily in the clinical area. But the original mission and the original thoughts were that we were going to reach these veterans within a year or two, bring them into the medical centers, and they'd all be cured.

Well, this turned out to be very far from reality in a couple of ways. One was that the medical centers and the outpatient clinics were fairly ill-equipped to deal with the kinds of problems being presented by the veterans that the Vet Center reached. It turned out that the Vet Centers became the place where the primary expertise was being developed, and, therefore, they were the ones that primarily began to deal with the problems.

The Vet Centers' main goal through all of this is to mainstream the veterans and to bring them into functioning within the community and to not create a dependency in that regard.

Senator AKAKA. As RCS has evolved, it has grown from a grass-roots peer counseling organization to a more professional service, so to speak, looking at you in front of me. In the process, some would argue something of RCS' original mission has been lost. Would you comment on that?

Dr. WEITZ. I'd like to comment, since I was a team leader in 1979. I think if you look at phases of any program, the initial phase in 1979 for a Vet Center program, our task was to establish trust, credibility, respect, and involvement of the veteran population that was isolated and estranged from traditional resources. In order to do that, we had to utilize very diverse counselors coming from a variety of backgrounds—gender, ethnicity—to reach populations that, by and large, were not going to get mainstreamed by their own choice into existing institutions.

That function was done admirably and successfully and continues to get done by a staff that is very diversified, not all of whom have the same professional education and training, but each in every way contributing to the total team concept.

I also believe, however, that once that phase of the program, although it may not be totally over, the credibility and trust and acceptability was astonishingly reached with a very difficult population. The next phase is to use information gained from our training, from the veterans themselves, expanding knowledge about PTSD and war trauma, and to implement that in effective treatment programs. Not every member of the team necessarily is responsible for duplication of every function.

I believe the team concept has allowed us to maintain networking, has allowed us to outreach populations, but I think the professionalism of staff in terms of psychological diagnosis and treatment allows us to achieve even further credibility as a clinical service.

I will say that when I came into the Vet Center Program as a trained mental health professional in 1979, the achievements that I valued were not valued by a lot of the people who looked at me in terms of my being a Vet Center team leader. I was overeducated, I was middle class, I was an officer. These were things that I believed were valuable. I think, over the course of time, everyone in the Vet Center Program, in terms of diversity, has proven their worth, and that's why the program exists today.

Senator AKAKA. Any other comments? Susan.

Dr. ANGELL. Yes, Senator, I'd like to add to that. I think the way our staff has developed where we have a combination of outreach workers and clinical workers really adds to our ability to meet more veterans' needs.

I'd also like to give a most recent example of where we still have a mission, and that mission is to go and get the veterans who can't get into the larger system very easily. I bring as an example our women veterans who have been sexually assaulted in the military. We have added to our mission that population, and I know that with the diversity of our staff, they will be reached with the same empathy and the same enthusiasm that we reached our Vietnam veterans with 14 years ago.

Senator AKAKA. Any other comments?

[No response.]

Senator AKAKA. The team leaders have increasingly complained of excessive reporting requirements, which takes valuable time better spent on clinical services. Moreover, such reporting requirements upon which management bases its performance reviews of veterans centers and individual counselors have become excessively quantitative or body count oriented. If this is true, what has been the effect of this body count policy on the quality of the Vet Center experience?

Dr. BATRES. Senator Akaka, I think that the Vet Center Program has received much more scrutiny than any other program that I'm aware of in the Federal Government. I believe that any program that has to justify its existence every year for 13 years based solely on the number of clients seen and visits, will create great stress on its employees and in the case of the Vet Center Program, lose validation for the quality clinical work being done with veterans.

I think what we struggle with is providing access to care to as many veterans as we can and yet provide quality care. I think the issue of quality versus quantity has been something that the program has always struggled with. But maybe what needs to be looked at is how the Vet Centers' effectiveness can be measured in areas other than numbers. Perhaps Vet Centers need to finally be acknowledged for the scope and quality of clinical and outreach services which the dedicated staff provides. Perhaps it is time to remove the sense of pending annihilation on staff and program, after 13 years of successful and veterans friendly service.

So my thinking on those types of requirements is that it's systemic and that we've had to generate those kinds of responses to survive and that maybe with your legislation that can be relaxed and we can focus more on quality of care and look at realistic caseload rather than to be surviving year-in and year-out solely by the number of clients that we see.

Senator AKAKA. Any other comments? Dr. Gelsomino.

Dr. GELSOMINO. I would like to say that I basically agree with what Dr. Batres had to say. I think that we've been in existence for 14 years now, and that's an awful long time to be justifying one's existence. I think that the Vet Centers have proved themselves.

I think there becomes a real morale factor when the Vet Centers look at the kinds of things they do and then compare it to the kinds of things that are required in the medical center, in terms of record keeping and that kind of thing, and I think it has a negative effect. I think that we don't get as many complaints as you might expect because of the dedication to what the Vet Center folks do, but it does have a negative impact on their morale.

Dr. WEITZ. As a team leader, I just would like to add, sir, that there has been a growing and significant increase—some positive, some negative—in terms of performance standards and spelled-out criteria. But I, for example, know no comparable psychologist in the VA system that has criteria built into their own performance evaluation in terms of productivity standards. I know of very few mental health systems, both in private and public sector, that evaluates staff in terms of client visits, new clients, and additional absolute administrative and productivity criteria.

I think that there's a certain point that, as a stepchild, either we're accepted by the family or we get very tired and fatigued trying to prove our value to the family. I think it's time for Vet Centers to be accepted as part of the VA family.

Senator AKAKA. Please compare the respective working cultures of Vet Centers with other VA services. In your opinion, is the Vet Center Program special? If so, what is it that makes it so unique?

Dr. Batres.

Dr. BATRES. Well, there are quite a few, but I think the one I would like to address is the fact that we're personal, that when veterans walk into a Vet Center, they're seen by another human being who appreciates their service to country, has some sense of what military duty is about. The vet will get a cup of coffee, and will be seen as quickly as possible, many times within half an hour of the time that they walk into the Vet Center.

I think it's that personal approach where we treat people with dignity and they don't have to wait in line. Foremost, I think, is the appreciation of their service to country which the Vet Centers offer, I believe pretty much uniformly across the country.

Senator AKAKA. Any other comments?

Dr. ANGELL. Yes, Senator. I think one of the most important qualities that make the Vet Center system especially effective is really some of the staff demographics. We really try very hard to match the people that we hire with the community that they're going to serve, as we expect them to become a part of the community, not just an outpatient clinic, but they're really an integral part of the community. Vet Center staff are usually very connected to other services that veterans might need. They take part in community events, be it a celebration or Veterans Day or parades, and that's really something that's par for the course for most of our staff and makes them a valuable part of that community.

I also think what we do that's different and unique is that we have numerous working groups that deal with all the different ethnic groups of the veterans that we see, and these groups work very hard all year round to develop resources, training materials, and to try to make the rest of the staff and advise management on how we can better meet the needs of any minority veterans.

Dr. WEITZ. I'd just like to add one comment. I think the underlying theoretical base of our program that may be interesting, and that happens to be that Vet Centers, from the outset, have focused on a health model which reinforces and supports people coping with life events. Veterans could continue to get seen and counseled even if they expressed and manifested healthy behaviors. In my experience, hospitals and the outpatient clinics focus on an illness model where veterans believe or feel that they have to maintain and show symptoms of illness in order to maintain their medication or their visits or to advance their claims and benefits cases.

I believe that there are many veterans who have made choices about going to hospitals or clinics as opposed to Vet Centers who basically exaggerate or behaviorally express their basic symptom patterns. They don't act that way typically when they come to Vet Centers. They have the ability to show health patterns, and that is what we've always advocated in our psychosocial model.

Dr. ANGELL. I'd like to add an example of what makes the Vet Centers special. I have a team in San Diego that yearly puts on a very large stand-down, and this is such a prominent stand-down that other VAs send their staff there to learn how to organize and do a successful stand-down. As a result of that, the team leader called me up and said, "You know, this is such a great thing and it works so well, why are we only doing it once a year? How would you feel if I tried to have a mini stand-down, bringing in people from the VA and other community resources on a weekly basis where the Vet Center opens its doors to the homeless veteran and tries to bring all those resources together on a weekly basis?"

My idea about that was, "If that's what the veterans in your community need, then you just go and do it, and you've got my full support." They didn't have to write a proposal, they didn't have to ask permission several levels up, and part of our autonomy allows us to be that flexible and that responsive. I could give that team leader an answer within our conversation rather than having to table it, staff it, and deal with it for the next year before we could come down with a decision.

So I think that's really an example of our responsiveness to veteran needs within the community.

Dr. BATRES. I have another example, a quick one, if I could, which involves our outstation in Hopi, Arizona. We've hired a counselor who is Hopi, Governor of one of the mesas, to be our person out in Hopi. Hopi is many, many miles away from the nearest medical center, which is in Prescott, Arizona—Phoenix, Arizona for some medical services. What Hopi is promoting is a community-based project. We have Hopi treating Hopi. The concepts of mental health in Hopi are different than the ones I was raised with and have been trained to address, but by hiring somebody indigenous to the community who understands the system, that person is providing culturally sensitive and relevant treatment to Hopi and Navajo warriors in Hopi.

Our biggest obstacle to that is getting a vehicle out on the reservation and going through GSA and getting permission and handling all of the bureaucratic challenges that one has to transcend to make such a program work, and I think the Vet Centers are excellent agencies or places where we can promote that kind of culturally sensitive mental health service delivery to our veterans.

Senator AKAKA. If Vet Centers were today placed under the administration and clinical control of local VA medical centers, what effect would this have on your ability to provide quality assistance to veterans, and are you aware of an institutional bias on the part of traditional medical services toward VA? Can you give some examples of that?

Dr. GELSOMINO. Being the historian, since I've been with the Vet Centers from the beginning and didn't have the gap in Hawaii that Dr. Weitz had, what I can tell you is that we have had an experience with the Chief of Staff basically being the supervisors of the Vet Centers, and by that I mean that originally when the Vet Centers were first started, they referred to the administrative setup as a dual supervision where the Chief of Staff or designee would be one of the supervisors and the regional coordinator would be the other supervisor.

In effect, what happened as a result of that is because the Chief of Staff was at the medical center at the time that their performance appraisals were done, the Chief of Personnel would go to the Chief of Staff or the designee, that person would do the appraisal, and everybody was well aware of this. So in effect there has been a time when the Chief of Staff has been the supervisor of the Vet Centers, and during that period of time there were numerous kinds of problems.

I think that there were some different motivations. There were certainly different priorities from the folks that were put in charge of the Vet Centers at that point in time, and it really wasn't until 1982, when the structure was changed to its current form, that the Vet Center really began to work and function the way it is today.

Dr. BATRES. I think that under the chiefs of staff, the ability to be innovative and flexible would be greatly reduced, and I think the kinds of things that make the Vet Center special would be lost.

Dr. WEITZ. Senator, I have worked as chief of psychology services in Army medical centers. I have seen the battles over budget and FTE and allocations of resources. I can assure you, in my experience, that nonmedical providers do not fare well in medically-controlled environments when physicians are making decisions about allocation of resources. Traditionally, someone like a chief of staff would not be all that concerned or involved with traditional psychiatric/psychological mental health services to begin with. My sense is that they would allocate those responsibilities to psychiatry.

I believe that while certainly our current director, as a psychiatrist, has done an admirable job, that traditional psychiatry and medical model thinking has not been consistent with the strengths of the Vet Center Program. I believe the issues would be that RCS team leaders, who are not used to those kinds of turf battles in hospital settings, would not fare well in terms of budget and manpower and program initiatives and creativity, and such a shift would stifle and be a way to destroy the heart and soul of the Vet Center Program.

Dr. ANGELL. Senator, I think one of the biggest losses that we would have under a chief of staff would be the dedication that we have to hiring combat veterans to do the very work with other combat veterans that we have now. I don't think there would be as great an effort in providing a good match to the community with a good match in the counselors, both ethnically and experientially. I think that would be a tremendous loss.

I think we would tend to get the more traditional social worker/psychologist/nurse kind of person that works very well within the larger VA system, but may not be able to translate as well to the very flexible, quick-moving program that we have.

I can give you an example of a situation where I think we get treated a little bit poorly. One of our headaches is leasing, and we have to go through these unbelievable procedures to lease a Vet Center. One of the Vet Centers that I was in, had to be moved out of one building and go to another. Besides being a long, arduous task, one of the things that occurred was that we found a historical building to place the Vet Center in, and it had to go through an inspection process. When the assigned inspector came out, he

looked at the building and said, "Well, cosmetically it looks pretty good. Structurally it's not very good, but it's good enough for you people."

I think that's an example of some continuing poor treatment sometimes and lack of respect treatment that we deal with as a program.

Senator AKAKA. What is the consensus of opinion in Vet Centers about the advisability of opening up the Vet Centers to other veterans, and should a distinction be made between combat and noncombat veterans?

Dr. ANGELL. Senator, I feel personally very strongly about that. I think that the Vet Centers have always been a place where the theater veteran can go and receive help and care, and that really has been a population that our society has not embraced, for the most part, since Vietnam on, which is very important in terms of receiving care. If society doesn't embrace you, then neither do the larger agencies that it has. Whereas, the Vet Center really goes out of their way to bring these populations in and make sure they get every bit of care and benefit that they can.

I think our most recent example, bringing up the women's issues again—women who have been sexually assaulted are another whole population that society trashes and throws away and says, "We don't want to hear from you." This is another population that I think we'll be very good at.

If you take a look at other veterans that maybe had either a training accident or just some other difficulty within the military, I don't think that's as identifiable a population that's going to have the difficulty accessing a larger system that our theater veterans and women who have been sexually assaulted have. So I think it's important, since we only have a certain amount of resources, that we really stick to our mission of trying to reach the hard-to-reach veteran and the veteran who's going to really need those special efforts that we provide.

Senator AKAKA. Any other comments?

Dr. WEITZ. Not wanting to suggest that we've seen veterans who are not eligible for the program, I've been fortunate in seeing veterans that had eligibility because they served in multiwars—World War II, Korea, and Vietnam. Interestingly, however, many of their traumas or issues were not related to Vietnam, but to Korea, for example. So it's very clear to me that the issues of trauma don't go away with time and, in due respect to Senator Simpson, that a calendar or clock doesn't measure health needs or health services.

I do suggest that we have primarily been known and utilized in dealing with combat and combat-related trauma and that those are the groups that we've had the greatest experience with. I certainly think the idea of expanded eligibility is an idea whose time has come in terms of equity and fairness and justice to veterans. I do caution, however, that if we open the door to some of the elderly veterans and senior veterans where trauma is not the major issue, I certainly think that resources and additional training becomes a reality, because mental health treatment of the elderly is quite different than psychological treatment of, say, a peer of the same age or a younger veteran in terms of potential for change and where they are in their lives.

So while I support totally the concept, I certainly want to caution that it does mean possibly looking at additional resources, and therapeutic approaches may have to be modified.

Senator AKAKA. What is the average current caseload per Vet Center counselor? What is the optimal caseload?

Dr. GELSOMINO. Well, in terms of pure numbers, the current requirement would be for the individual counselor to spend approximately 24 hours a week in direct clinical service delivery. I think that given a comparability with a mental hygiene clinic, that probably is not too far removed from the kinds of clinical work that go on in a mental hygiene clinic and a Vet Center that's providing clinical work pretty much within its walls.

However, I think that if we're talking optimal, then optimal ought to mean something where we adjust based on the environment of the particular Vet Center. There are vast differences between rural and urban kinds of centers. The amount of outreach you do, the kinds of things that you do in terms of travel are much more extensive than somebody in an urban setting. I think if we got into a situation of optimal, I think it would be to tailor the requirement to that local Vet Center's needs, community, and environment.

Senator AKAKA. Are you aware of any survivors of military personnel killed in the line of duty who are being seen in veterans centers for bereavement counseling?

Dr. GELSOMINO. I can say, going back to 1979, that probably the most difficult thing a Vet Center would have to do would be to ever turn away a Gold Star mother or a family member of somebody who died in combat, and I'll very openly say that the Vet Centers in my region have provided that as long as they've been in existence whenever they were asked to.

Dr. BATRES. I'm very aware of that, Senator. When I was team leader in East Los Angeles, I had a Gold Star parents group as a family group, and though they didn't count in the official report and they weren't eligible, we saw them, we worked with them, and I think that I can think of no other group that has given so much to this country as Gold Star parents and families. So I strongly recommend that this is a group that really deserves to be eligible for our services.

Dr. ANGELL. I would agree with that. In our region, I know we have a number of children of veterans who were killed in the Vietnam war who are being seen, and that is seen as a very important and significant part of what we do, even though we don't record it.

Dr. GELSOMINO. Let me just add one more thing. I think there's even a therapeutic spinoff to the whole process, because one of the things that we've seen is that the veterans who are there in the Vet Center receiving therapy are very much attracted to and attached to those folks that have lost somebody in Vietnam, and I think it's an opportunity and a vehicle for them to work through some of their survivor guilt in terms of the way they respond to the Gold Star mothers and families of KIAs, and vice versa. I think that the Gold Star mothers have also gotten something from relating to the veterans that served with their sons.

Senator AKAKA. Since this has been an issue, let me ask you, how key is confidentiality to RCS client relationships and the success of RCS' mission?

Dr. WEITZ. Earning the trust and respect and confidence of veteran clients who were initially estranged and disenfranchised and very paranoid about the Government was not an easy task. One of the major ways this was supported and accomplished was the assurance by Vet Center staff, to unbelievable degrees, of the confidentiality of the information that would be contained in client files and the restriction on access to that information. I believe that for Vet Center counselors, team leaders, and regional staff, this remains a critical issue in terms of maintaining the bond and trust that we have earned over the years and not losing that credibility.

I believe that it's more of a threat now, with the age of computers and the easy access and transmission of information, and being able to get into data bases that become more open than paper files. I think it becomes a real concern, and I am personally aware of, a number of years ago, a research study that did request information that could in fact track and access veterans who were receiving care who participated in this legitimate research study, without requiring the need to initiate a voluntary agreement with veterans to participate in the study.

I must say that as a psychologist, that practice violated my professional ethics. I would not comply with the research protocol without giving every veteran the opportunity of reading the release form and agreeing whether or not to participate in the study. I must say, Senator, that 50 percent of the veterans who were asked at that time refused—I repeat, refused—to have that information released to the general VA system. So there is a concern in the veteran population.

Senator AKAKA. Would Vet Centers profit from the additional benefits personnel available at VVRCs? For example, would you have more time for clinical services and outreach?

[Witnesses nod affirmatively.]

Senator AKAKA. I see the answer is yes.

Dr. GELSOMINO. Yes, and this is in fact being done at places where there are VVRCs in place.

Senator AKAKA. Are at least some veterans avoiding treatment in VA's hospitals and OPCs because of their dislike of bureaucracy or because of the distances involved?

Dr. ANGELL. Senator, I think that's been the case all along since our program started, and probably why we've been successful and a necessary part of the VA is to be available to the veterans who can't go into the medical center, whether it be a distance question or just an emotional barrier, given the bureaucracy and the sense that they may not get treated well or they may not get treated within a reasonable time frame.

Senator AKAKA. Would these same veterans, do you think, be willing to access primary health care services if offered through Vet Centers?

Dr. WEITZ. I believe, sir, that that's really a fascinating question, because as our veteran population, our original primary treatment group, approximates close to 50 years of age in the Vietnam veteran population, I myself am seeing tremendous amounts of cor-

related medical problems—extended results of diabetes, carcinomas, neurological dysfunctions, alcohol and drug effects over long-term use. What I'm seeing clearly is that we not only have psychological and mental health issues, but clear physical medical issues that are a part of the veteran's problem.

The difficulty is in utilizing medical centers or outpatient clinics, which are equipped to handle those problems. One, the accessibility of those services in terms of timeliness and frequency of visits and communication of information becomes a problem. Second, as you mentioned, there's the trust issue, whether the veterans will go to the medical centers for those services.

So it's a fascinating question in terms of either collocation or utilization of some kind of medical care support within the Vet Center configuration. I would recommend, however, that serious consideration be not to adopt the concept of physician staffing, where we run into issues of authority and power and the medical model, but to the concept of corpsmen, in which the veterans themselves have always utilized and believed in, through use of staff like nurse clinicians or physician's assistants.

They've always trusted their corpsmen, and I would certainly consider that, if you're going to utilize either collocation concepts or integration, that the medical personnel you include in facilities to provide some basic screening and followup care services, not specialization care, might be very useful in the long run to move costly inpatient care to efficient outpatient treatment.

Senator AKAKA. Let me ask the last question, because there's a vote on and I'm going to have to get there. This can be a fast answer. What would be the clinical impact on regular Vet Center counseling programs if medical personnel were allowed in Vet Centers? In other words, would it have a chilling effect on clients?

Dr. GELSOMINO. I think Bill's point is a very good one. I think that certainly the medical screening kinds of activities are very compatible. We do have examples out there right now that that combination is working well. I think one of the critical elements in all of it has really been the way it's been designed. The community that you do it in, how you set it up, I think, are very critical issues in all of this. But the need, as Bill mentioned, is going to be an increasing one.

Senator AKAKA. Well, I thank you very, very much for your responses, and I'll tell you that what you've said will be helpful to us. Thank you very much.

There is a fourth panel that will be here. I'm going to run to vote, and I'll be right back. So at this time, the Committee stands in recess.

[Recess.]

Senator AKAKA. The Committee hearing will come to order.

Our final panel consists of additional witnesses who work with veterans centers. We have Steve Molnar, team leader, Honolulu Veterans Center; Clyde Poag, team leader, Grand Rapids Veterans Center; Cliff Balenquah, Counselor, Hopi Outstation, Kearns Canyon, Arizona; Mike Loy, team leader, Reno Veterans Center; and Dr. Daniel Doyle, team leader, Richmond Veterans Center.

Well, we'll begin with Steve.

**STATEMENT OF STEPHEN T. MOLNAR, TEAM LEADER,
HONOLULU, HAWAII VET CENTER**

Mr. MOLNAR. Aloha, Senator. I'm pleased to be here today.

Senator AKAKA. Aloha, and welcome.

Mr. MOLNAR. Thank you. As you know, I've been the team leader of the Honolulu Vet Center since 1979. The Honolulu team consists of five full-time employees, two of which are permanent counselors, a temporary Persian Gulf counselor, an office manager, and the team leader. All of our staff have graduate degrees. All are veterans, two of which served in Vietnam. A quarter-time social worker has recently been hired to deal with the issues of women's sexual abuse, and she should be on board as we speak.

We also have the opportunity to have a full-time Disabled Veterans Outreach Program employment counselor on board, thereby offering completely computerized employment and training services for our veteran population.

Since opening in 1980, the Honolulu Vet Center has served over 6,000 eligible veterans. Up until 1988, we also provided readjustment counseling services to the neighbor islands. However, since 1988, as you are aware, Vet Centers were established on each of the major neighbor islands. Most recently we have begun working with Persian Gulf veterans and have been involved in numerous related community activities.

As a community-based organization, the Vet Center has made significant contributions to our community. These include coordinating three PTSD Statewide conferences, coediting a publication for our Hawaii veterans entitled "Employment Benefits for Veterans in Hawaii," coauthoring a published article on Asian veterans, participating in several veterans research projects, helping to establish the Hawaii Vietnam Veterans Leadership Program, initiating the first annual candlelight memorial service at Punchbowl National Cemetery and establishing one of the first military PTSD groups with Dr. William Weitz, at the Tripler Army Medical Center in Hawaii. We've also been involved in a number of things with the Hawaii State legislature, including passage of the nation's first full tuition waiver for Vietnam veterans.

As you may know, many of the veterans who finally came into Vet Centers in 1980 no longer had GI eligibility. Recognizing this problem, the Honolulu Vet Center worked closely with the Hawaii State legislature to ensure passage of legislation to provide full tuition waivers to Vietnam theater veterans who attended any community college within the State or at the University of Hawaii itself.

I think that speaks for some of the types of things a Vet Center can accomplish as a community-based organization, and it speaks for the State of Hawaii in being a part of the process of the homecoming and the healing of our veteran community.

That is a summation of my testimony, Senator. Thank you.

[The prepared statement of Mr. Molnar appears on p. 120.]

Senator AKAKA. Thank you.

Mr. Cliff Balenquah.

STATEMENT OF CLIFFORD BALENQUAH, COUNSELOR, HOPI RESERVATION, PRESCOTT, ARIZONA VET CENTER

Mr. BALENQUAH. Good afternoon, Senator. Aloha.

Senator AKAKA. Aloha.

Mr. BALENQUAH. [Remarks given in Native language.]

I am pleased to be here today to brief the Members of this Committee on activities on the Hopi Reservation. The Hopi Reservation is located in northeastern Arizona, approximately 236 miles from the closest vet medical facility in Prescott, Arizona. The Hopi Vet Center Outreach Office is a unique operation, being that it is one of its first kind located directly on an Indian reservation, and it is staffed by myself. I am knowledgeable in the tribal cultural heritage, and I speak the native language. The outstation serves the entire Hopi Reservation and portions of the Navajo Nation, the White Mountain Apache Tribe, and the San Juan Southern Ute Tribal Areas, an area which covers 65,500 square miles.

There are approximately 300 different American Indian tribes, and they have served in the Armed Forces in large numbers. About 10 percent of all living American Indians are veterans.

I live on the Hopi Reservation, where I am available 24 hours every day to assist and provide immediate service. I am fluent in the Hopi language, and I participate in our tribal religious ceremonies. I understand and speak the Navajo language, with limitations. I am a Federal employee and a member of the Hopi Tribe, which is a federally recognized Indian tribe. We enjoy a sound government-to-government relationship with our government at the department level.

I am part of the Prescott Vet Center team, and my coordination with the team is excellent, and their understanding and availability is extremely efficient. Although my office is 236 miles from Prescott, the cooperation of everyone has been overwhelming, which makes my mission a pleasurable task.

Indian tribes are culturally diverse, although many of the principal beliefs remain constant. This makes it advantageous for a native-speaking, culturally knowledgeable person to be employed who can relate to these language differences, religious ceremonial differences, and the differences in combat-related PTSD healing ceremonies, coupled with tribal beliefs and taboos.

There are certain taboos at the Navajo Tribe. It is taboo for Navajos to give or receive a blood transfusion, as it is believed that the original blood giver will come back and reclaim their blood. Some of these things must be known. Some of these things must be respected in order to have these services with respect on the reservation.

There are numerous examples of cultural barriers to VA care regarding Native American veterans. A Hopi veteran being questioned by a physician nodded in agreement, which pleased the smiling, nodding physician. Unknowingly, the veteran only picked up bits and pieces of the English language. I then intervened and asked the veteran in the Hopi language if he understood what he was answering to. His reply was no. I asked why he nodded to indicate a yes answer. His reply was that the physician was speaking too fast and was nodding as he spoke to him. I then interpreted

the questions to him in Hopi, and many answers had to be changed.

An Apache Vietnam veteran continually sees a striking resemblance between the Vietnamese and himself, particularly in the body size and skin coloring. This an Anglo counselor saw as insignificant.

There are other barriers. Few facilities are located near Indian reservations. The distance is usually great. 236 miles is not actually a short drive. Reliable public transportation and communication services are lacking. There is distrust of the Federal Government due to past broken treaties, cultural misunderstanding of special Native American needs, and nonveteran counselors who cannot relate to the traumas of combat.

There are high rates of postwar psychosocial problems among Indian veterans, and having Indian veteran counselors counseling other Indians enhances the readjustment transition back into the tribal society and Bahana society, Bahana being the Anglo.

Few studies, if any, are available on the American Indian combat veteran and the interplay of PTSD and cultural compositions. Tribal clan structures and the extended family clan system are vitally significant to the warrior's homecoming and the readjustment process. Because the warriors have fought battles, they should not only be honored, but also purged of the taint of battle and restored to a harmonious place within their community.

Tribal religious practices are sometimes viewed as primitive by those unfamiliar with Indian culture, but these practices have been done for hundreds of years, and they are effective for Indian veterans. I have witnessed the process, I have participated in the process, and I know veterans who have become productive citizens based on these practices.

Outreach is necessary for other purposes, such as promoting the Indian veteran, the Vietnam veteran, and other veterans to a positive image, promoting and providing ways to express pride of their warrior status, promoting unity in tribal and Federal Government concerns, and remembering those brothers and sisters who have paid the supreme sacrifice.

I am a member of the Rattlesnake Clan and the Reed Clan. These kinds of connotations in Indian circles make it important that culture become very important. You must become sensitized to these areas, because it takes an Indian to know an Indian. Many of the cultural differences within the society have been put aside, and now is the time to be aware of these areas.

American Indians are proud people. We have served the country for a long time. A Navajo code talker was denied VA services when he had to take a written test. He later commented to the instructor, "No one ever asked me if I could speak or write the English language fluently. All they were concerned with was if I could use a rifle and shoot with accuracy."

Because as many of the Indian veterans came off the reservations, they came back to the reservations, and when you go back to your native-speaking people, you speak that language. When I come to Washington, I speak your language, but [remainder of remarks given in native tongue]. This is particularly true with older veterans.

I am the only one that's located out in the Hopi Reservation for these services. I do not turn anybody away, because I'm the only one. When Desert Storm operations came around, when I had crying grandmothers, wives, brothers, sisters come into my office, I had to take a hard swallow and make sure that I do the right thing. Some of my experiences from my combat situations in Vietnam came back pretty fast. I had to be strong for them, because I wasn't going to let them down.

So today many of us still see these things, but many don't realize how important culture is, and certainly Dr. Batres and other regional managers are taking a good look at this. Because American Indians will always be here, there is a need for cultural sensitivity to this.

I do know that American Indians are earth people. They have a special tie to nature, to the earth, to the constellations. This religious, cultural, traditional healing, coupled or entwined with the western theory of counseling, enhances the American Indian veteran back into society—not only his society, but also the white man's society—and I believe this is well done now in the VA, or at least at the Vet Centers, at least what I've experienced up to this point.

Senator I would be available to answer any questions that you have. Thank you.

[The prepared statement of Mr. Balenquah appears on p. 121.]

Senator AKAKA. Thank you very much.

Mr. Loy.

STATEMENT OF MICHAEL LOY, MSW, TEAM LEADER, RENO, NEVADA VET CENTER

Mr. LOY. Mr. Chairman and Members of the Committee, I'm pleased to be here today to brief the Members on the activities of the Reno, Nevada Vet Center.

Reno is on the border just near California. To the east is about 250 miles of high desert. We have veterans traveling down that road to come see us sometimes 2 or 3 hours away. Those veterans come once a week to get counseling. To the west is California—mountainous areas, not such a far distance, but traveling through mountain passes, up and down mountains, through valleys, especially in the wintertime, takes a great deal of difficulty, and it is sometimes impossible to get to see us.

The Reno Vet Center has been in operation since 1981, April of 1981, and provides services to Vietnam era and post-Vietnam combat/conflict veterans, and women veterans suffering from sexual harassment and/or assault.

One of the strengths of the Vet Center Program comes from the small team structure. Within that structure, clinical team members have the freedom to develop creative solutions to problems that are specific to the populations and communities being served. Examples of these creative solutions are the development of services to urban homeless veterans through cooperative efforts among the veterans' service organizations, community services, and Vet Center staff. Housing and job training programs have been developed.

Stand-downs reaching out to provide immediate and meaningful assistance to homeless veterans is another example of innovative

assistance to homeless veterans, many of whom suffer chronic mental illness. During stand-downs, the whole community is organized to provide a wide range of social services to those in need.

Native Americans living on reservations are being served through the Vet Center Program by bringing services to them directly. Other rural veterans are also in need of services, and strategies to provide services to them are currently being developed through the Readjustment Counseling Service Special Working Group searching for ways to provide access to care for rural veterans.

I'm the chairperson for that special working group. Members of that group have spent a lot of time searching for solutions. They're looking at Russia, seeing how they provide health care and mental health services in rural areas. We've had members in contact with people in Australia, seeing how they provide services in that vast area to Vietnam veterans from Australia.

Quality clinical care is provided by the Vet Center Program through continued efforts of reaching out to unserved and underserved veterans in both urban and rural populations by locating veterans in need, providing immediate assistance when possible, and referring veterans to a VA medical center or outpatient clinic or community resource when necessary. The Vet Center is able to assist in providing a continuum of care for those veterans in need of service.

In conclusion, the very nature of the Vet Center mission and structure makes it possible to be responsive and innovative in providing outreach and clinical services to the veterans we serve.

Thank you.

[The prepared statement of Mr. Loy appears on p. 122.]

Senator AKAKA. Thank you very much, Mr. Loy.

Dr. Doyle.

STATEMENT OF DR. DANIEL G. DOYLE, TEAM LEADER, RICHMOND, VIRGINIA VET CENTER

Dr. DOYLE. Aloha, Mr. Chairman.

Senator AKAKA. Aloha.

Dr. DOYLE. My name is Dan Doyle, and I was hired in 1981 to open the Richmond Vet Center. Two of my three staff that I hired then are still with me. We see on a daily basis the chronic aspects of PTSD, and I believe I'd lump them into two groups. One would be the individual symptoms—nightmares, flashbacks, whatever—which are dealt with in terms of specific treatment techniques.

The other aspect that's chronic I call an attitudinal issue, and that is that the veterans—Vietnam veterans, in particular, and that's the majority that we see—do not feel accepted, do not feel that they belong, do not feel understood or respected—not just by the traditional VA system, though that is, by and large, true, in my opinion, but more than that, by the larger society—and not feeling that they belong to the country that they served leaves them in a very difficult position.

I believe there's a lot of ignorance, superstition about mental illness. That's one of the reasons that I actively started when I opened the Vet Center, soliciting approval from the Medical College of Virginia in Richmond for Virginia Commonwealth University to

have the Vet Center established as an internship training site, and it has been in a number of professional areas. We offer a 1-year predoctoral internship in clinical psychology, a 1-year internship at the Master's level for Master's of social work, rehabilitation counseling, and psychiatric nursing, and 3 years ago began a program and were accredited by the Medical College to teach group therapy to third-year psychiatry residents.

For the last 4 or 5 years, we have averaged five graduate students in training each year—typically, two social work interns, two psychology interns, and a psychiatry resident. One of my requirements for the students is that they commit to 1 year with the veterans, because many of the complaints I've received in terms of other kinds of medical care in the larger VA system are that they see a different doctor each time they come because the doctors rotate from orthopedics to neurology to whatever the rotations are, and the veterans get the feeling of being shuffled, that he never sees the same person twice, the continuity of care, the sense of belonging, the sense of ownership that "This is my patient. This is my veteran. I'm responsible for his care."

That feeling, that attitude is lacking among the larger system, as perceived by many veterans, and I put the requirement on that they serve 1 year for the training.

[The prepared statement of Dr. Doyle appears on p. 122.]

Senator AKAKA. Mr. Poag.

STATEMENT OF CLYDE POAG, TEAM LEADER, GRAND RAPIDS, MICHIGAN VET CENTER

Mr. POAG. Good afternoon, Senator Akaka. I appreciate the opportunity to appear before your Committee and to talk about some of the issues particularly of African-American veterans. I'm the team leader at the Vet Center in Grand Rapids, Michigan. Grand Rapids, Michigan, is the second largest city in Michigan. Most people always ask me, "How far is that from Detroit?" I've been the team leader at the Vet Center in Grand Rapids since 1981.

One of the things that we have been doing—the Grand Rapids Vet Center, in cooperation with local community agencies, recently was awarded a grant by the Department of Housing and Urban Development. Actually, the award was to the Grand Rapids YMCA, and we collaborated with them to provide services to homeless veterans. As you're aware, a large percentage of people that are homeless are veterans. That program is running now, and the grant provides a rent subsidy to the homeless veterans who are in that program. I think presently we have about 27 men in the program, and it will house 30 men when the program is full.

Veterans accepted into the program are afforded stabilized housing for as long as 10 years. The veterans have been diagnosed with a wide range of readjustment problems, including chronic mental illness, substance abuse, and post-traumatic stress disorder. These veterans were alienated from their families and friends and became homeless due to their conditions and other problems.

The three criteria for acceptance into the program are that the veteran be homeless, have a disability, and have an acceptable discharge. The veterans are seen in individual and group counseling. Benefits and employment counselors as well as rehabilitation and

recreational specialists are available to assist these veterans. In addition, veterans have access to all of the YMCA facilities, including the health club and exercise facilities. Presently, several of the veterans are employed on a part-time basis, and we have five of them who have enrolled in local colleges.

This program is successful largely because of the cooperation between the VA medical center in Battle Creek and the VA outpatient clinic in Grand Rapids and a wide range of community mental health and other agencies in the local area. Our program has been used as a model in other communities to look at some of the services that can be provided to homeless veterans.

As in the general population, a large percentage of homeless veterans are African-Americans, and this is true for our program also. More than half of the men who are in the program are African-Americans. The National Vietnam Veterans Readjustment Study showed that African-American veterans experience high levels of PTSD as well as other readjustment problems. The RCS Working Group on African-American Veterans is concerned about these and other issues that need to be addressed. The Grand Rapids Vet Center is striving to meet the needs of this group along with the other clientele.

I'll be available to answer any questions you might have.

[The prepared statement of Mr. Poag appears on p. 123.]

Senator AKAKA. We're glad to have all of you here bringing different experiences, and this certainly will be helpful to us. I will ask you questions that all of you or none of you may answer, and in the interest of time, I hope you can do it as quickly as you can.

What is so special about the Vet Center Program as opposed to other VA programs? I am particularly interested in your answer, Steve, since you were one of the program's original hires.

Mr. MOLNAR. Thank you, Senator. I think what's special about the program is the people who do the work—their commitment, their dedication to, I think as Dr. Weitz said earlier, to being involved in the healing of veterans, not the illness of veterans. I think it's the opportunity to allow a veteran to walk into a Government facility and be greeted almost immediately and to be helped with whatever issue or problem he or she may bring into that center. By help, it may be something as simple as explaining a benefit the veteran.

Vet Centers work for the veteran. I think that most of us who have worked with veterans have heard from both individuals and service organizations of the belief and feeling that there is a lifetime commitment made by their Government in trade for their services, and we in the Vet Center, I think, sincerely believe that we are there to work for the veteran and provide the services that he or she may need.

I think if we look at the satisfaction levels that we've seen from the population we've served, it's been very, very high. There have been very few complaints. I think it's the opportunity to be innovative, to do the kinds of programs and things that work for the veteran population. It's been mentioned a number of times today that we don't have to go through a series of committees, a series of discussions to do the kinds of things that work.

Earlier you asked about whether or not the Vet Center could or should come under the more traditional bureaucracy and why or why not that should be the case. I can give you a couple examples of my own experience over the years. When we were under the chief of staff in 1981 and 1982, a request to have a newspaper so veterans could look for employment or housing was denied. We had to go before a committee to discuss whether or not a newspaper is the right thing for a VA program to purchase.

In another instance, when working with veterans who were coming off of alcohol and substance abuse, we began to form baseball teams and volleyball teams to provide them with more health activities. We were told that this was not an appropriate service to be provided at the Vet Center. "If you want a Vietnam veteran to be involved in sports activities, refer him or her to the day treatment center with other psychiatric veterans."

These are the kinds of things, as a community-based organization, that we've been able to do. I think the legislation that we were involved in in Hawaii to pass a tuition waiver, the legislation for Agent Orange research, the legislation for a Korean and Vietnam memorial, our involvement would not have been possible had we been a part of the larger system.

I think we're unique, too, because the veteran community knows we do these things. They know that the VA is involved in these things by way of the Vet Center. In 1987 we brought the replica of the Vietnam Memorial Wall to Hawaii, and we had it at the State capital. 30,000 of our citizens came forward, individuals who cannot easily come to the wall here in Washington, to come and pay homage to their native sons, to their contributions. The community for 1 week was deeply involved in what we were doing in the healing process, and this has been part of the Vet Center's mission, to share the healing process.

Coming home from war is not the responsibility of the VA mental health clinic. It's the responsibility of the community, and we, as a part of the community, I think, are special in being able to provide that.

I'll stop there and let some of my colleagues go on.

Mr. POAG. I think one of the things that is unique about the Vet Centers is that we have the ability to be flexible and to respond to the needs of our particular community. I think that has been good. We have gone out and developed resources. For example, we have a wide range covering western Michigan, and we've gone out and found places where we could outstation counselors, and subsequently the VA medical center has outstationed their counselors from their PCT programs and other programs and have utilized some of the resources that we have developed.

I think the fact that the Vet Center has the credibility and the experience in the community has been good, it has allowed the medical center to oftentimes utilize outreach in some of the communities where they haven't outreached before.

Senator AKAKA. Are there any other comments?

Mr. BALENQUAH. Not only are they unique in different respects, but particularly my operation—and I have to brag about that a little, because there's none other on an Indian reservation—working with the different Indian tribes, you become involved with a variety

of problem issues. Although I would say that many of the American Indians have this little umbrella of animosity toward the Government, we get many tribes—Apaches, Utes, Navajos—we have some Hispanics, we have some blacks, we have some Anglos that are married into the tribe who are also veterans, and they come and express their part. Every race, every tribe, every culture has a very rich beginning, and even some of the Anglos would come and say, “Well, my people were from Ireland.”

We listen to all these things, and there’s a bond there because we served in the Armed Forces together, and many of them—I would say most of them—are Vietnam veterans. Some of the older ones will come in and teach us about the different concepts of tribal warrior societies. Believing that this is something that is really a true identity to the American Indian, this makes my operation unique.

Not only is it just there, but when I do outreach, like when I go to Prescott to the Vet Center there, I also include some of this information with other veterans that I meet. So, in essence, I’m kind of like the reporter or the newsperson that goes and helps teach others how to understand one veteran with another one.

Senator AKAKA. Any other comments? Dr. Doyle.

Dr. DOYLE. What makes the Vet Center Program special to me is the area of personal responsibility that comes with the autonomy of our independent chain of command, and by that I mean 26 years ago Congress made me an infantry lieutenant and sent me to Vietnam, and my job then was to chart a course across unfamiliar territory, through hostile natives, and accomplish whatever mission the higher command gave to me. When I came back from Vietnam in 1969, I went back to college on the GI bill and majored in psychology to try to figure out what was wrong with me, why I was different, why sometimes I was the only one in class and my peers were demonstrating against the war and doing other things.

What I found in the Vet Center Program is I’ve got the same job, and what’s sad to me is that the unfamiliar territory is the bureaucracy that is not understood or that’s not welcoming, and the hostile natives are, it’s my belief, the vast majority of Americans my generation and older who do not want to accept the responsibility that Vietnam veterans—all combat veterans—went in this country’s name. Whatever is said about Vietnam veterans was done in the name of my generation and my father’s generation, and my father fought in World War II and Korea.

The autonomy of the Vet Centers, the independence allows me to say, “I’m going to do this because it’s the right thing to do,” and an example is I was called one day by a DAV service officer who had done a lot of good work for many of our Vietnam veterans, and he asked me for a favor, and he asked me to evaluate a World War II veteran who could not be seen at the hospital on an outpatient basis because he was not service-connected.

He was a Marine who was wounded the first time in the first wave in the assault on Iwo Jima, was in the hospital for months and went back through several other island campaigns and was wounded again, used the GI bill, got a Master’s degree, and taught for 25 years, 30 years. When he retired from the work that organized his mind and his world, he had too much free time. What

came back in his mind was not the pleasure of retirement and enjoying grandchildren. What came back to his mind were deaths, destruction, nightmares, anger.

But he wasn't eligible. Nobody would listen to him. They offered to give him a prescription that he could get filled with tranquilizers at a private pharmacy. I would not turn the man away. He was my brother and could well have been my father. But I could do that, and I did do that.

Thank you.

Senator AKAKA. Any other comments?

[No response.]

Senator AKAKA. We talked about confidentiality. How important is confidentiality to the Vet Center Program? What is your opinion on that?

Dr. DOYLE. It's very important. An earlier panel member mentioned that 50 percent of the veterans, when given the choice, turned down releasing their research information to the larger system. In the training programs that I've run with psychology, social work, and psychiatry students, and I've also served on dissertation committees for two doctoral dissertations and four master's theses, that issue comes up every single time, and in my experience more than 50 percent do not want—they want a copy of the research for themselves or at the Vet Center, but they do not want it in the larger system, and their concerns are fear that it would be used against them in some way.

Senator AKAKA. Any other comments?

Mr. MOLNAR. Yes, Senator. I think it's extremely important, and it's not something that really can be compromised. When the Vet Center Program began in 1979 under P.L. 96-22, there was a section there in that stated something to the effect that no veteran's records will be released to any outside agency, including the Department of Veterans Affairs, without the veteran's permission. I think that's an important and significant reason for the program's success today.

The word gets out on the street very quickly amongst the population that the Vet Center is a place you can go and you can really tell whatever you want to talk about. Whether it's a World War II veteran talking about mistakenly killing civilians, he at least knows that he has some control over that information. When working with individuals who have PTSD, control and feeling empowered are extremely important. Veterans need to know that the deep, dark secrets that wartime produces are not available to anyone. They need to know that when they walk into the mental health clinic, the clerk looking at them hasn't read their file. The best of agencies and the best of people cannot give the veteran that kind of confidentiality when he or she knows it is available to others.

In that sense, particularly with older veterans, a population which is often afraid of mental health stigmas, I think it's important that we keep confidentiality as it is. Also, I think most veterans do not want to feel like they're ending up on a mailing list for research, either. They want to be able to have some say and some control over that. So I think it's extremely important, Senator.

Senator AKAKA. Any other comments?

[No response.]

Senator AKAKA. Please comment about the need for expanding entitlement to combat and noncombat veterans and for bereavement counseling for Gold Star families.

Dr. DOYLE. It's my belief that expanding the entitlement to combat veterans, theater veterans, and to Gold Star families—in my experience in Richmond, the numbers who seek such help are a relatively small number, but they are coming to the specialty place. It's the sort of thing that what's associated with the larger VA system is "There's something wrong, we'll give you a pill, and we hope you'll be out in 15 minutes," and that is diametrically opposite to the needs of the folks, what they're asking for. They want to talk. But in my experience, it's not a large number, large percentage.

Senator AKAKA. Other comments?

Mr. BALENQUAH. Senator, I also feel likewise. Even though I'm serving all of the—when I say "all," all areas of veterans—I find it necessary that it extends beyond just the veteran itself. Like, I have children of Vietnam veterans at the high school, at the local high school there. I visit the jail on the reservation where veterans are and some of the children are also. So I believe that some of the services need to be opened up.

I have three Gold Star mothers. I have a family of a missing-in-action from the Vietnam war. That's very hard to deal with. So I would say it would be advantageous to open it up to all veterans. I don't think the numbers would be that great, and let's hope that many of them have cured themselves either through their cultural practices or through the western practice. But, nonetheless, I think it should be.

Thank you.

Senator AKAKA. Mr. Poag.

Mr. POAG. Senator, I think a lot of the people that do not, particularly in our community, utilize the Vet Centers, it's because we're not technically designated as a resource center, but we have a wide range of services that are provided there, and I think it's easily accessible. The Vet Centers are located in the community, and so people can easily stop there for information.

We have been involved with several Gold Star mothers. One year we took a group of Vietnam veterans to see the Vietnam Veterans Memorial when it was dedicated, and some of the people that were on that trip were Gold Star mothers, and they asked the counselors a lot of different questions that showed that there were some ongoing kinds of issues and needs that needed to be addressed by them, and we've had them stop in several different times to ask information of us.

So I think war veterans and providing services to them, I think that's something that I know that the Vet Centers could do and do quite well, and I also would be kind of concerned about Gold Star mothers who might would need the same kinds of support and assistance.

Mr. MOLNAR. Senator, I'd also like to address that. Where does a Gold Star mother go? She's not eligible for VA treatment. In rural communities, there may not be a support group for her. I've had the opportunity over the years to work with a number of families and Gold Star mothers, and the opportunity for them to ask

simple questions, like, "What does this medal mean? Was my son a hero?" to be able to share some of that with another human being, particularly in many of the minority cultures where it's more traditional to be stoic, to not talk about your losses, to hold your head up and go on, to be able to have someplace where one can come and talk about what she has felt is important.

In the case of some Vietnam veterans, I've had mothers come to tell me that their son was a good boy, he was not a bad boy—again, looking at that negative stereotype of the Vietnam veteran. I've had mothers bring me cookies, pies for being a part of their healing process.

As regards expanding the services to other eras, I certainly am in agreement specifically with the combat veteran. I think we need to look back with the World War II and Korean veterans and understand that they were socialized in a period where mental illness was a real stigma, and we've talked about that today, where it was a very taboo subject, where we looked at individuals who had those difficulties as either being cowardly, unmanly, or something of the sort.

It is not easy for World War II or Korean veterans suddenly to "get it" as far as mental health issues. It's a very large step for them to walk under a sign that says "Mental Hygiene Clinic," to admit that they have some mental illness, that they have some emotional problems.

I wish that Senator Simpson were here at this moment, because I think he had shared some of his feelings that issues that happened 43 or 45 years ago should not be affecting someone today. Well, my experience in working with individuals who have been traumatized—POWs, survivors of the Bataan Death March—I think that is an insult to them to say that they should not be bothered by what happened 43 years ago.

I've worked with a veteran, and I wish he were today to share some of his own experiences. He is a Korean-American, although the DOD and the VA at times referred to him as a Jap and a Chinese and a Mongolian and a Cororean—C-O-R-R-E-A-N—and a number of different labels. He served in both World War II and Korea, and he spoke the Korean language. He was an interrogator, and he was wounded and captured, and he spent 30 months as a POW.

He has, since his POW experience, had nightmares, a variety of nightmares—nightmares of being beaten, nightmares of not escaping. Because he could speak the Korean language, and could therefore probably "pass" outside of the camp, he had some guilt that he did not escape for his fellow soldiers. He has nightmares about what the Korean guards did to him because they were angry that he was an American and about Americans who didn't trust him because he could speak Korean.

In 1957 he had his first psychiatric break. He was treated for combat neurosis and eventually completed his military tour and was given a 20 percent disability for psychiatric problems. He eventually came into a Vet Center. Why? Because he no longer could deal with his issues. He no longer could handle his issues.

He came into the Vet Center in 1990 because the Soviet Union was falling, and I, in my foggiest mind, couldn't understand what

that would have to do with anything. But, in his mind he feared that North Korea would also fall, North Korea, and he suddenly had to do something before he died. He had to go back and, now that North Korea was falling in his mind, he may now have to go and do something for the parents and the families and identify the graves of other POWs. He may be able to go back and discover whether he had buried his comrades deeply enough and hope that the dogs hadn't gotten them. This caused his nightmares to come back, the falling of the wall in Europe.

He was not able to go to the VA because he didn't feel that he was a mental health case. He came to the Vet Center, and I think we were able to make some real progress. We were able to handle his anger to the point that he was able to go for a comp exam, and he's now rated at 100 percent. At the very least, we gave him the dignity to live out the rest of his life. That's one of a number of examples of World War II and Korean veterans we have worked with.

I'll turn it to my colleagues at this point, unless you have some questions, Senator.

Senator AKAKA. I'm sure all of you were here when my good friend Senator Simpson made his comments. Does anyone wish to address the comments made earlier by Senator Simpson?

Dr. DOYLE. In my work with career military, retired military, many of whom were three-war vets—World War II, Korea, or Vietnam—uniformly, every single one of them say that Vietnam was the worst of their three wars, partly the nature of the war, the guerrilla war nature of it, but largely because of the homecoming—the rejection by their society and community, which, in my mind, is a much larger issue than the stigma of mental health and having to admit to having a mental health problem.

It's more than the stigma. It's "I want to tell you something," and nobody wants to listen. It's part of my commitment in that sense to the training program that I run, to educate people, the younger generations specifically, that these things do last a lifetime.

Senator AKAKA. Mike Loy.

Mr. LOY. I worked 13 years in a VA outpatient clinic and a mental health clinic and worked with a wide variety of patients, clients. Two of the most memorable—one was a World War II veteran who was a POW and who had been medicated mildly by the VA, and that's the treatment they provided him. The treatment he provided himself was working 6 or 7 days a week, 10 or 12 hours a day. I was able to assist him by listening to him and saying, "Yes, I will listen to you and work with you."

Another was a World War II and Korean veteran who had a successful career in World War II and then was wounded in the Korean War and felt a lot of shame for having been involved in a situation where his people under him were wounded. He was medicated. That's the treatment that was provided to him. Again, I was able to say, "Yes, I will listen to you."

I think that's what the Vet Center can do best is say, "Yes, we will listen to you, and we will be of help to you the best we can."

Mr. POAG. Senator, we had a World War II veteran that came to the Vet Center, and as we took a military history from him, we found out that he had been captured in Germany and had gone on

a march of 23 miles, I think he said, through the snow and was a POW for several years. He had gone to the VA medical center for treatment and in fact had received different psychotropic medications and had been treated for his substance abuse issues and problems, but the trauma and the problems and the nightmares that he had as a result of the POW experiences were never addressed.

He subsequently asked to meet with some of the men that were attending our rap group, and he did meet with them because he felt that he could identify with them and some of the combat experiences that they had had and some of the problems that they were experiencing. Subsequently, he did meet with them a couple of times, and I think, as reported by him, he really did benefit from the experience.

I think most of the Vet Centers can document similar kinds of examples of World War II and Korean War veterans that they've had encounters with.

But to kind of address some of what Senator Simpson said, I think that the Vet Centers provide the services at a very reasonable cost, as the saying goes. We provide a wide range of services. Certainly, the Homeless Veterans Program that we provide counseling and support to in Grand Rapids is done without any additional resources. Providing services to homeless veterans takes up a lot of time, because they need a lot of services, from financial to housing to medical to dental. So it's a wide range of services that have to be provided to a veteran that's homeless. Emergency assistance, crisis intervention.

Those services are provided with the limited resources that we have, with the existing staff, with no additional staff, and we're having homeless veterans coming in without having to do any outreach to get them. They come to the Vet Center.

Mr. BALENQUAH. Senator, I also have one veteran who is a former POW from the Korean Conflict, and before he didn't have a place to go. Although he would speak with his wife, his wife practically told him, "Don't talk about it anymore." When he found out that the outreach office was on the Hopi Reservation, he willingly came and started talking with some of the younger veterans, younger combat veterans, and he has been a great help to me, not only to myself, but also to the other veterans and to himself. Most recently, his wife has joined us, and she understands a lot of what had happened.

So I believe that I'm a little bit appalled at what the Senator had mentioned, because if the Department of Veterans Affairs is to keep that title—I don't want it to become a misnomer by not having some of these issues discussed from all areas. That's one of the reasons why, too, I am in favor of having it open to all veterans.

Thank you.

Mr. MOLNAR. I'd like to say, Senator, that I think currently we are seeing the World War II and the Korean veteran when he or she presents himself or herself. There really is a back-door kind of philosophy. We're asking them to come to the back door, and if we have the room, we'll see them. I think that these individuals deserve more than that. I think they deserve our full attention.

Thank you.

Senator AKAKA. Returning to you, Cliff, you're permanently assigned on an Indian reservation. What special role can a veterans center play in outreaching veterans in remote rural areas and locations? Can other services match what RCS is doing in these areas?

Mr. BALENQUAH. Senator, I am currently a temporary employee of the RCS, and some of these services that are provided by RCS cannot be matched, mainly because this is the first of its kind, and I don't believe there has been any concentrated efforts by Vet Centers who are located close to reservations to try to get out there. I may be wrong. Perhaps maybe there is a counselor that goes out to the reservation twice a week, three times a week, depending on the need.

But this is so important not only from the standpoint that you do have Indian veterans on reservations, but you do have services that are close by. When I say "close by," probably within a commuting distance of, I would say, 50 miles at the closest. In my opinion, this becomes very necessary, because many of them will not come into the Vet Centers or into the medical centers or into the Indian Health Service, mainly because of the bureaucracy.

So when you do have an Indian going out in the Indian reservation or even located there, it makes it a lot easier for them, and I believe that many of the team leaders and counselors have expressed their need or at least their desire to become involved with these. The only problem that I would see right off is, who is willing from the Indian tribes to come and communicate with them on some of these cultural issues?

Senator AKAKA. In contrast to remote rural locations, Clyde, as an inner city team leader who is experienced at counseling minority veterans, would you agree that Vet Centers are well ahead of the rest of VA in sensitivity to minority concerns? If so, can you explain why this is so?

Mr. POAG. Well, I absolutely do, Senator, because, as was said before, we have special working groups for the different populations that we address. Presently, I'm chairman of the African-American Working Group, and it is something I think that is unique for the Department. I know that the Department has EEO counselors and others, but the working groups that we have look at the particular issues of special populations and try to address those issues and bring those issues and needs and problems to the attention of the regional managers and to the directors of the program.

Certainly, I know that some of the things that we are looking at are employment, recruitment, retention of African-American counselors, office managers, team leaders, and regional managers in our program, and looking at devising programs—for example, the women veterans sexual trauma counselors recently held a conference to look at the training needs of those counselors who will be addressing the needs of women veterans who were sexually traumatized and abused in the military. Well, one of the things that we know is that the issues of African-American women veterans need to be addressed, and the training that was provided did not address some of the issues that were concerns for African-American women veterans.

But that program and that training was not put on by the Readjustment Counseling Service, and I think if it had been, I think it would have been more sensitive to the needs of special populations. When we have our trainings, for example, minority presenters oftentimes are the facilitators for various workshops and trainings, and that has been a policy of the program. I can't say that that's true for the Department in general.

Senator AKAKA. My final question to all of you is, and I really appreciate your patience, is there any comment or thought you'd like to leave with the Committee? After all you've said and after all I've asked, I'll give you a chance to express anything else you want to say to the Committee.

Mr. POAG. Well, if I may, Senator, just to continue, Cliff has eloquently talked about some of the particular cultural issues of Native American or Indian veterans, and I'd like to bring to the attention of the Committee the fact that African-American veterans have unique problems as a result of serving and fighting in Vietnam. Specific efforts were made by enemy soldiers in regard to propaganda that was specifically directed at African-American veterans. They were subjected to discrimination and racial incidents in Vietnam.

The national study that was done on the readjustment issues and problems of Vietnam veterans showed that African-American veterans have upwards of 20 percent diagnosable post-traumatic stress disorder, yet the National Centers for Post-Traumatic Stress Studies, which has a relatively large budget, has not adequately addressed the needs or looked at some of the precipitating issues and reasons why that is true.

Those are some of the things that we're concerned about. We think that the needs of African-American veterans should be looked at and that it should be a priority for the Department and for the National Centers.

In addition to that, the women veterans sexual trauma counselors that are being hired, we are concerned about the fact that there are a small number who are African-American women, and we think that those types of issues and particular concerns—because we do have a culture. We have a specific language, problems, culture, and those things are not looked at as it relates to readjustment issues of African-American veterans, and I think it should be a priority.

Mr. LOY. As chairperson of the Readjustment Counseling Service Rural Working Group, I'd like to emphasize the needs of rural veterans, the lack of availability, and the problems of accessibility to services for rural veterans, and I'd like to provide you with our recommendations in the future when our paper is finished, hopefully in November.

Senator AKAKA. Thank you.

Mr. BALENQUAH. Senator, I'd like to add that I am rather disappointed by the nonattendance of the Senators here for this special hearing. I can't see any price greater than freedom, and apparently there are some other priorities that the Senators do have, and I want to truly, sincerely thank you for bringing this bill to their attention.

There are special groups. Everybody is a special person, and I know the people that I served with while I was in the military really brought that to my attention. I had some very good Hawaiian friends. One of my closest buddies was a black in Vietnam. But I also feel that American Indians, minorities are certainly deserving of a small portion of this \$37.5 billion that's being allocated, and I think with your help they can really make a difference.

As long as we're going to be here, there are going to be conflicts, and as long as there are going to be conflicts, there are going to be veterans, and it is our responsibility—and I say ours because we have gone through that, and we come to you for help. We come to you asking for your assistance. Don't turn us away this time. Let's see if we can't at least have maybe a small portion of this \$37.5 billion. But I am most thankful to you.

Thank you.

Mr. MOLNAR. I would just like to say, Senator, thank you for being concerned about not only Hawaii's veterans, but our Nation's veterans.

Senator Rockefeller this morning talked about forgotten heroes, and we've over the years discussed the eligibility question of World War II and Korean veterans, and my fear is if we do not make the impact now, they will not just be forgotten heroes, but they could be rated as ignored heroes, and I think if they are heroes, we should not ignore them. We should not ask them to seek permission to come in for readjustment counseling services. We should not force them into mental health clinics if this goes against their socialization or their values.

I think we've also learned today through the testimony that PTSD is a chronic illness. It is something that can revisit an individual 50 years later, and that should not surprise a single one of us, and that's on the record. We're not going to cure PTSD. We're going to help individuals who have PTSD. We're going to allow them to manage their PTSD symptoms. One of the first things that I tell a veteran when he walks into my center is, "I cannot cure you, but I can help you," and I think we're making that impact.

I think we're making also the recognition that mental illness and such issues still have as stigma, and we cannot ignore that, particularly for our older veterans.

In closing, again, I thank you for the interest you've had in the Vet Center Program, for the opportunity to look at this program, a program that has worked very well, that has served many, many veterans, and I would hope that we can continue it.

Thank you, Senator.

Senator AKAKA. Thank you, Steve.

If there are no further comments, I want to thank all of you. I believe this hearing has helped to shed light on VA's mental health and readjustment counseling services. On behalf of the Committee, I want to extend to all the witnesses our appreciation for your patience in helping us learn more about VA's programs and the ways in which we can improve services to veterans. Your advice and expertise will add and contribute much to our work as the Committee moves this legislation forward.

Again, thank you very much, and I wish you well in your trips back to your homes. If there are no further comments or testimonies, this hearing is now adjourned.

[Whereupon, at 4:20 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

APPENDIX

PREPARED STATEMENT OF SENATOR ALAN K. SIMPSON

Good morning Mr. Chairman. I would take this opportunity to welcome Deputy Secretary of the Department of Veterans Affairs Hershel Gober and all of the other distinguished guests on the varied panels who are here today. I am most pleased to be here for this hearing regarding VA mental health programs.

While I look forward to hearing the testimony regarding the mental illness research, education and clinical centers legislation, I will start by applauding my fine colleague and dear friend from Hawaii, Senator Akaka on his compassionate and well-thought out legislation regarding readjustment counseling services. I do not say this lightly, for I know he shares a most sincere concern and a true desire to help this Nation's veterans. I share those concerns with him.

But, as many of you know I also share a most valid concern regarding our Nation's economic situation and the current state of affairs with regard to a burgeoning debt of \$4.2 trillion. With that in mind, I simply want to call the attention of the Committee to a letter which I ran across in the "Stars and Stripes" military newspaper from a grassroots veteran working as a local veterans employment service representative in Illinois.

His letter speaks about Vet Centers, and indeed, it is titled, "Vet Centers: Do We Still Need Them?" He starts by saying that "the statistics they (other Members of Congress) used to scare the heck out of Congress were the estimated hundreds of thousands of wartime veterans and their families who may need, or will need, special readjustment counseling because they either have, or will have, post-traumatic stress disorder (PTSD)."

He continues, "These figures will go through the roof if the Senate manages to convince the House to add WWII and Korean war veterans and members of their families. If Congress goes one step further and includes peacetime veterans and their families, this would qualify all veterans and almost our entire population." These are not my words—these are the words of a fiscally concerned grassroots veteran advocate who possesses over 10 years experience with Vet Centers and readjustment counseling services.

He goes on to speak about the myriad of costs to veterans because of this system and the draining of essential funding for other VA programs. As he says, "We were of the understanding that the Vet Centers were first established in 1979 on a temporary basis to provide special readjustment counseling and special employment assistance for the unusually large number of Vietnam-era veterans who were having trouble readjusting because they were out of the mainstream . . . in other words, they did not want to go through the normal process of applying for assistance with the public employment service(s) and the VA like the vast majority of other vets did."

He also says that "the Vietnam war has been over almost 17 years, and we can't figure out where all the veterans are coming from that may still need special help. Indications are that the traffic in these Vet Centers has dropped considerably during recent years." He even mentions that some of the disabled Veterans Outreach Program Specialists stationed at Vet Centers ". . . see it as a waste of their time and taxpayers' money . . . [and that] . . . they feel they could be helping hundreds of veterans in their local offices."

He says that he has personally talked to thousands of veterans in the northwest part of Illinois and he has not seen any veteran who required referral to a Vet Center.

Finally, he closes the article by saying that "One of our biggest concerns . . . is that the more you tell veterans that they may be sick, the greater their chances are of becoming sick. In order to compete, veterans need to be in the mainstream seeking work . . . the time has come for Congress to take a long, hard look at the Vet

Centers. Since they already duplicate the services of employment services and VA, one consideration might be to transfer the Vet Center counselors to employment services and VA . . . [which would] . . . save this country close to \$1 billion a year."

This is certainly a powerful article and in my opinion, it is extremely valid coming from a grassroots veteran who has worked "out in the field." While I am not advocating as strong of an action that the author suggests, I must say I am most concerned that the legislation which we are considering today, flies completely in the face of reasoning according to the arguments I just cited. Thank you, Mr. Chairman.

PREPARED STATEMENT OF CONGRESSWOMAN MARCY KAPTUR

Mr. Chairman and Members of the Committee, I thank you for your leadership in holding this hearing and for this opportunity to testify today. May I offer my wholehearted support and cooperation as a Member of the House Veterans Affairs, Housing and Urban Development, and Independent Agencies Appropriations Subcommittee as you assess VA care of chronically mentally ill veterans. In my opinion, there is no more overlooked set of illnesses than those involving the chemistry and function of the brain. The need to address this issue is evidenced by the finding that 40% of veterans treated at VA medical facilities have been diagnosed with psychiatric disorders. Each year approximately one-third of the hospital beds in VA facilities are occupied by patients with these illnesses.

First, let me address the issue of research so fundamental to achieving breakthroughs to properly treat these illnesses. Although 40% of VA patients receive treatment for mental illness, only 11.2% of the FY 1992 VA medical research budget, the latest year for which figures are available, was directed toward research in this area. Further, research psychiatrists and neurologists are exceptions on the peer review committees the VA employs to select and award research grants. Thus, it is not surprising these illnesses do not receive the attention they warrant. There is a serious need to realign VA research priorities to parallel the characteristics of patients treated.

Despite receiving only 11.2% of the VA medical research budget, the results of serious mental illness research have enabled veterans to become functional again. Once they would have spent the rest of their lives in hospitals, disabled by hallucinations, crippling paranoia, unremitting depression, or a gut-wrenching panic disorders. Even greater breakthroughs should be expected during this "Decade of the Brain" because of growing national awareness about the necessity of significant research advances in these fields. A recent NIMH study prepared for the Senate Appropriations Committee indicates that clozapine, for example, has helped nearly one-third of the people diagnosed with schizophrenia who had previously been unresponsive to all other treatments. Due to serious side effects, however, research is continuing to develop medication with clozapine's benefits without some of its side effects. There is no better time to increase support and attention to VA mental illness research and treatment—especially such serious debilitating illnesses as schizophrenia and bipolar disorder.

A coordinated emphasis on psychiatric research by the VA and the National Institutes of Mental Health (NIMH) would help a great deal, and would be most beneficial, to achieving even greater success in the treatment of chronically, mentally ill patients. Language included in the House VA, HUD, Independent Agencies appropriations report for FY 1994 recommends that the VA and NIMH Research Review Committees jointly work together to submit a report on ways to improve coordination of psychiatric research efforts. I believe testimony you will hear today from NIMH will elaborate on their suggestions for coordination with the VA.

Research directly leads to treatments for mental illness that lead not only to a more humane existence for millions of citizens but incredible cost savings as well. The NIMH study indicates that treatment success rates for panic and bipolar disorders are 80%, major depression 65%, and schizophrenia 60%, while angioplasty and atherectomy, two cardiovascular treatments, compare at just 41% and 52% respectively. The treatments, both drug and psycho-social, promise incredible savings to the U.S. economy, which lost over \$136 billion in 1991 due to direct and indirect expenses associated with mental disorders. NIMH calculates that the development of lithium alone already has saved more than \$40 billion since 1970. These calculations are based on the U.S. population at large, of which 22% will experience some kind of mental problem during their lifetimes. When one considers at least 40% of our veterans are similarly affected, the impact on the veteran population and the VA should be even greater.

The need for coordinated research efforts is essential. I understand, Mr. Chairman, that you plan to introduce legislation to establish mental illness research, edu-

cation and clinical centers (MIRECC's) to focus more research on all mental illnesses, and I commend you on this approach. As you know, existing VA Geriatric Research, Education and Clinical Centers (GRECC's) have proven very successful. Additional research will constructively benefit veterans who now often are turned back out into society, only to return for treatment again and again. I would caution you, however, to link your initiatives to current VA mental illness research and expenditures to ensure that these efforts are not forgotten or duplicated with the establishment of a MIRECC system.

Increased support of the VA's Health Care for Homeless Veterans (HCHV) Program (formerly the Homeless Chronically Mentally Ill (HCMI) Program) offers another effective means to treat chronically mentally ill veterans. At least one-third of our Nation's homeless are veterans. A large percentage of these homeless veterans also suffer from mental illnesses, often complicated by alcohol or drug addiction. In my Northwest Ohio district, a VA study conducted last year found that of the approximately 4,500 homeless individuals in Northwest Ohio, 1,500-1,700 were veterans. The study also found that of that number, approximately 65% were alcohol dependent and 35% were drug dependent, many presenting with dual diagnoses. These distressing figures led me to pursue the establishment of an HCHV veterans program in Toledo, Ohio, which, I am glad to say, will be fully operational within 4 months. By working with various community organizations and walking the streets in areas common to the homeless population, HCHV outreach workers will make contact with homeless veterans. It is estimated that the Toledo HCHV program will identify, assess and rehabilitate 600 homeless chronically, mentally ill veterans each year. Nationally, since its inception in 1987, the HCHV program has helped over 30,000 homeless veterans suffering from psychiatric and substance abuse disorders in 26 States and the District of Columbia. And over 8,000 were placed in non-VA residential treatment facilities.

To demonstrate the necessity for this hearing today, I would like to tell you a story about one homeless veteran. The day before Thanksgiving of 1992, a story appeared in our local newspaper describing Phil, a homeless man who lived in a tent on the banks near the Maumee River. An old school friend of Phil's read the story, and went to the bridge to pick up Phil and take him home for Thanksgiving. His friend went on to assist Phil in trying to find medical help and job training and literally had to beg doctors to examine Phil, and others to find him shelter. Then he and Phil came to meet with me in my office shortly after Thanksgiving. During the course of our conversation, his friend told me that Phil had been diagnosed recently as suffering from paranoid schizophrenia. I asked his friend if Phil was a veteran. They both looked and looked at each other and Phil perked up and answered yes, he was a veteran. In all of the agency contacts Phil and his friend had made in the previous weeks, no one had asked whether Phil was a veteran!

Phil had been on the street for years with no care, because no one had ever found him and, once they had, inquired as to whether he was a veteran, and thus eligible for VA assistance. After my question, with his friend's help, Phil was admitted into the VA mental health care system, was given medicine to help his condition, applied for and began receiving benefits, and consequently was set up in an apartment. His transition has not been easy, as I understand it—he has disappeared on occasion and fallen off his medication. But thanks to the VA health care system, at least there is the hope of help and perhaps one less veteran will be on the street.

There is a vast unmet need for residential treatment or transitional housing for mentally ill veterans who receive treatment at VA medical facilities. I will never forget a scene I witnessed while visiting the Hines VA Medical Center near Chicago. A veteran was being admitted to the Hines Hospital for the 17th time. Each time, after being treated and becoming acclimated to his medication, he was sent back to the streets of Chicago. But sure enough, 9 months later he wandered out or was brought back to West Chicago for more treatment. Would not transitional housing, in which a veteran such as this could be monitored, be more effective in the VA's long-term rehabilitation efforts?

The VA, HUD, and Independent Agencies FY 1994 Appropriations bill as approved by the House, directs \$10 million to implement the homeless veterans comprehensive service program authorized last year. As you know, this program offers Federal support to community-based organizations who provide transitional housing assistance, outreach, rehabilitation services, and vocational counseling and training assistance to homeless veterans. A program such as this directly reaches out to the hundreds of thousands of veterans who walk our streets each day and offers them concrete, tangible help. I urge you to continue pursuing this approach.

Finally, I commend Senator Akaka on his legislation, H.R. 1226, emphasizing the importance of mental health in assessments of a veteran's ability to readjust to civilian life. A veteran's mental state is as important to his or her chance of success as

are job skills and education. Increased attention to a veteran's mental health could open the way for expanded use of community support systems to help veterans and their families adjust together to such a dramatic change in their lives.

Encouragement and support of expanded VA mental illness research, rehabilitation of homeless chronically mentally ill veterans, and transitional housing which allows for monitoring of veterans treated for mental illness, are constructive ways in which to return these veterans to the lives they wish to live. I urge you to move the VA into a more significant national role in focusing care and treatment of chronically mentally ill veterans, and in turn help us find answers for our population as a whole. Thank you again for this opportunity to testify.

PREPARED STATEMENT OF DR. DENNIS CHARNEY, CHIEF OF PSYCHIATRY, WEST HAVEN VA MEDICAL CENTER, AND PROFESSOR OF PSYCHIATRY AND ASSOCIATE CHAIRMAN FOR RESEARCH IN PSYCHIATRY, YALE UNIVERSITY SCHOOL OF MEDICINE

My name is Dennis Charney. Currently, I am Chief of Psychiatry at the Department of Veterans Affairs Medical Center in West Haven (VAMC-WH), Connecticut and Professor of Psychiatry and Associate Chairman for Research in Psychiatry at the Yale University School of Medicine.

The Psychiatry Service which I direct at the VAMC-WH is a large and complex one. It consists of 188 psychiatric inpatient beds, outpatient clinics with a workload of over 60,000 clinic visits each year and specialized treatment programs for patients with Schizophrenia, Post-Traumatic Stress Disorder, Depression, and Substance Abuse. Further, we have developed a variety of highly regarded psychiatric rehabilitation programs, designed to help patients with chronic mental illness, obtain adequate housing and return to productive vocational pursuits.

The Psychiatric Research Program at the VAMC-WH is among the largest in the VA Health Care System. For example, we are the site for the Clinical Neuroscience Division of the National Center for Post-Traumatic Stress Disorder (Director, Dennis S. Charney, M.D.), one of two VA funded Alcohol Biological Research Centers (Director, John H. Krystal, M.D.), and one of three VA funded Schizophrenia Biological Research Centers (Co-Directors, Dennis S. Charney, M.D. and B. Stephanson Bunney, M.D.). Most of our psychiatrists are not only expert clinicians dedicated to patient care, but are also VA and NIMH funded investigators committed to the discovery of new improved treatments for our patients. These psychiatrists are also full-time faculty members at the Yale University School of Medicine and, as such, are also devoted to the education of Yale medical students and psychiatric residents who receive training at the VAMC-WH.

Thus, in view of my clinical care, research, and educational responsibilities in the VA Health Care System, I appreciate the opportunity to discuss with the Senate Veterans' Affairs Committee issues related to VA Clinical programs for the chronically mentally ill, VA funded psychiatric research initiatives, and the importance of maintaining strong and mutually beneficial medical school affiliations.

PREPARED STATEMENT OF DR. MATTHEW J. FRIEDMAN, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER, WHITE RIVER JUNCTION, VERMONT

The National Center for Post-Traumatic Stress Disorder (PTSD) was mandated by the U.S. Congress in 1984 under Public Law 98-528 to carry out a broad range of multidisciplinary activities in research, education, and training. Such initiatives support system-wide efforts to understand, diagnose, and treat PTSD in veterans who have been exposed to traumatic stress during their military service. The current National Center, which was established in 1989, is a 7-art consortium with divisions located in White River Junction, Vermont, West Haven, Connecticut, Menlo Park, California, Boston, Massachusetts, and Honolulu, Hawaii.

The Center is a world leader in research on psychological, psychophysiological, and neurobiological aspects of PTSD. Such activities include the development of diagnostic assessment tools, identification of biological markers, and developing effective treatments for PTSD. Although the Center has a core recurring budget that supports many of its staff members, it depends on VA-sponsored research programs for much of the research it conducts. Examples of some current VA-sponsored projects are as follows:

- The Psychophysiology Cooperative Study tested over 2,000 veterans from 15 VAs across the country. It will improve diagnosis in veterans who seek treatment for PTSD.

- The Women's Trauma Consortium Project is working on a number of studies relating to the health status, symptom evaluation, and treatment of female veterans from WWII, the Korean conflict, Vietnam, and Operation Desert Storm.

- The Ethnic Minorities (Matsunaga) Study is an epidemiological survey of the prevalence of PTSD among American Indian, Native Hawaiian, and Asian-American Vietnam veterans. Its results will assist the VA in providing appropriate diagnosis and treatment of PTSD in minority veterans.

- There are two longitudinal studies of veterans who served in the Persian Gulf during Operation Desert Storm. Both will help clinicians identify individuals who may be at risk for developing long-term problems after military service.

- The Clinical Psychopharmacology Program testing the effectiveness of Prozac and Clonidine for treating PTSD.

- The Clinical Laboratory is testing an innovative treatment for veterans dually diagnosed with both PTSD and alcoholism/substance abuse.

- The Evaluation Division is assessing treatment outcome at PCTs and SIPUs throughout the VA system.

The National Center's PILOTS (Published International Literature on Traumatic Stress) computerized bibliographic database has indexed 5,400 titles to date and has an international following of scholars, researchers, and clinicians. It is accessible to almost anyone who has a personal computer.

The National Center's number and variety of educational programs includes: publishing articles in professional journals, making formal presentations at scientific and training conferences, providing on-site clinical training opportunities such as fellowships, internships, and mini-residencies, presenting teleconferences, developing educational media such as videotapes, and providing consultation regarding education and training.

The National Center publishes two newsletters. The "NCP Clinical Newsletter" is distributed to over 6,000 clinicians and PTSD experts. The "PTSD Research Quarterly" is distributed to 5,000 researchers and scholars throughout the world.

The National Center has provided education, training, consultation, and clinical expertise during national emergencies including Operation Desert Storm/Shield, the Iraq/Kuwait hostage crisis, the Loma Prieta earthquake, as well as Hurricanes Hugo, Andrew, and Iniki. In this regard it has collaborated with DoD, State Department, and Red Cross. Other collaborative activities have involved HHS, DoT, and DoC.

PREPARED STATEMENT OF DR. JOHN O. LIPKIN, CLINICAL PROFESSOR AND CHIEF OF STAFF, DEPARTMENT OF PSYCHIATRY, PERRY POINT VA MEDICAL CENTER, UNIVERSITY OF MARYLAND, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

I. INTRODUCTION

Mr. Chairman and members of the Committee, I am John O. Lipkin, M.D., Clinical Professor of Psychiatry at the University of Maryland, Chief of Staff at the Perry Point VAMC, and a member of the American Psychiatric Association's Committee on Veterans Affairs.

I appear before you today on behalf of the American Psychiatric Association, a medical specialty society representing more than 38,000 psychiatric physicians nationwide.

I have been actively involved in the acute and long term care of people with psychiatric illness since 1970 when I began two years at the Bethesda Naval Hospital as a staff psychiatrist. I worked as the Chief of the Psychiatry Service at the Portland Oregon VA for seven years, and then worked as the Associate Director of the Mental Health and Behavioral Sciences Service in the Central Office of the VA from 1979 until 1986. I have been the Chief of Staff at Perry Point for seven years.

I am pleased to have an opportunity to testify today about the VA's programs for the treatment and rehabilitation of the chronic mentally ill as well as pending legislation concerning Mental Illness Research, Education, and Clinical Centers (MIRECCs) and S. 1126, the Readjustment Counseling Services Amendments of 1993.

II. BACKGROUND

A. Definition of Mental Illness

As a clinician, it is my experience that there is often a great deal of confusion about what is meant when we refer to mental illness.

A mental disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R), published by the American Psychiatric Association, as "a clinically significant behavior or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more areas of important functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom."

It is important to note that there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, or between it and no mental disorder. In fact, as DSM III-R notes, "a common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have."

This fact in particular is an important example of how persons with a diagnosed mental illness are subjected to often unintended discrimination, in that they are often referred to as "schizophrenics" or "manic-depressives", allowing the illness to define the person. This is not the case with other illnesses such as cancer or coronary disease, for example.

In my personal view, we cannot separate a host of psychological, biological, and social factors that contribute to the development of mental illness. Clearly, the biology of mental illness has been rapidly clarified through research over the past twenty-five years. More progress has been made in understanding how the brain works in this period of time than in any other area of basic human biology.

I personally believe that more and more of our understanding of mental illness will be based on new knowledge about brain anatomy and chemistry. As a result of this information, new pharmacologic treatments will become more and more specific and useful. However, each improvement in our biologic understanding and treatment ability will require parallel efforts in the areas of psychological and social rehabilitation.

B. Historic Context of Discrimination

Because persons with mental illness sometimes display behavior outside of social norms, they have historically been ostracized, abandoned, or isolated in remote asylums. Many of the explanations of the aberrant behaviors associated with mental illness invoke assumptions—rooted in ignorance and fear—that persons with mental illness are not "really ill" but instead show moral weakness and/or lack of self control.

Public mental health programs existed to make sure that the mentally ill would not create problems or upset the sensibilities of the ordinary citizen. Of course, it is also true that there have been compassionate people with more humane motives who have worked hard to improve conditions for the mentally ill.

Even within the medical community, mental illness has been controversial and subject to misunderstanding and prejudice. Whenever an illness causes behaviors which are unusual, it is characterized as a psychiatric illness until a clear treatment becomes available for it. Syphilis, porphyria and some vitamin deficiency syndromes were left to psychiatrists to treat until effective non-psychiatric medical treatments were found for them.

Many confused or agitated conditions, such as those commonly related to infection and high fever remain the business of internists, neurologists, and surgeons because they may be caused by viruses, bacteria, dehydration, etc. These temporary behavior changes can happen to anyone and they often respond to available treatments. Ironically, other physicians often refer confused or agitated patients in the hospital for psychiatric consultation because they have not recognized the effects of infection or dehydration on the mental status of their patients.

Stigma and lack of clarity about mental disorders has led to institutionalized prejudice against those with the disorders and those who treat the disorders. As noted, even today many well educated and otherwise compassionate individuals persist in framing mental illness as "character flaws" when in fact there is a vast amount of epidemiological data which demonstrates that mental illness is readily diagnosed and treatment is both clinically and cost effective.

For example, recent National Institute of Mental Health (NIMH) data shows that treatment of severe mental illnesses, including bipolar disorder is up to 100% more effective than a commonly accepted medical treatment for cardiovascular disease such as angioplasty. Yet vastly more money is spent for research on heart disease than is spent on mental illness research.

Worse, while angioplasty and other treatment for cardiovascular disease is accepted as "routine" and "appropriate" and rarely if ever challenged on budgetary or effi-

cacy grounds, mental illness treatment is routinely subjected to micromanagement and inordinate interference and challenges by health insurance reviewers. It should be no surprise that most health insurance policies will fully cover non-psychiatric medical illnesses, but major mental illness, with its social stigma, is usually subject to specified limits on both inpatient and outpatient care. Even the Federal Government's Medicare program, for example, discriminates against persons with mental illness, in that Medicare beneficiaries must pay fully one-half the cost of outpatient care out of their own pockets, when every other Medicare Part B service carries a patient-borne coinsurance requirement of only 20 percent.

Sadly, the VA medical system is itself not immune from prejudice against treatment of mental illness. For example, there are more VA Career Research Awards for medicine in one single state—Iowa—than there are awards for psychiatry in the entire United States. In this context, it is not surprising that the Department of Veterans Affairs has not done much better in researching and treating mental illness than the rest of society.

III. VA TREATMENT OF PERSONS WITH MENTAL ILLNESS

In my view, effective treatment of the mentally ill requires sufficient access to all three major domains of concern: (1) biological treatment, (2) psychological treatment, and (3) "social" treatment.

When a person has been unable to perceive the world accurately and has neither worked nor managed the ordinary details of life without assistance for many days, months, or years, re-entry into the commonplace world will be exceptionally difficult. Thus, in order to retain the gains made via psychopharmacology and psychotherapy, individual patients need specific education, training, practice and support in precisely the same way an orthopedic patient needs specific education training, practice, and support following a hip joint replacement.

These combined strategies are an essential part of any successful treatment continuum and they admittedly are not cheap. It must be noted, however, that the modern treatment of mental illness has been at least as successful as the modern treatment of diabetes, coronary artery disease, or high blood pressure.

Unfortunately, during my twenty-one years in the VA, I have watched a persistent erosion of services available for my patients while patients with non-psychiatric chronic illnesses continued to have access to increasingly sophisticated treatment.

One experience I will never forget occurred during my first year in Portland in 1972. I was utterly amazed to find that VA Central Office had offered us a Day Treatment Program and a Substance Abuse Program, but hospital management had declined both programs without even discussing them with me, even though I was serving as the Chief of Psychiatry Services. I also learned that officials at the hospital did not really want any substance abuse patients around. In contrast, I observed repeatedly over time that the hospital would accept new programs whenever they were offered in medicine and surgery.

As a new service chief I had a lot to learn, but gradually I began to understand the VA budget process. In those days, VA hospitals were paid a flat per diem rate for each day of inpatient care they provided. Because the need for psychiatric care exceeded our capacity, it was not hard to keep our psychiatric beds full all the time.

As part of my annual budget development preparation, I quickly discovered that psychiatric services regularly generated a substantial budget surplus. In contrast, the medical and surgical programs failed to keep their beds at capacity and regularly ran up significant deficits. This meant that in addition to being desperately needed, psychiatric care was clearly self-sustaining, in that we in fact generated a surplus to the net benefit of the overall hospital budget. One would reasonably have expected the hospital's administrators to conclude that this experience demonstrated the need to expand psychiatry beds into some of non-psychiatric medicine's unused space. Patients and the hospital budget would both benefit.

Local medical politics, however, dictated otherwise. Despite the undeniable fact that expansion of psychiatric services would serve a demonstrated patient need and would simultaneously be of fiscal benefit to the hospital, the emphasis was instead placed on expanding medical and surgical services. Psychiatric services, in contrast, were maintained at a level sufficient only to manage emergencies and make referrals to other hospitals for psychiatric care.

The VA at that time made a distinction between long term "Neuropsychiatric" (NP) hospitals and other hospitals in the system. The NP hospitals and other hospitals were generally poorly staffed, far away, and unaffiliated. Service Chiefs and Hospital Directors often got their first assignments in NP hospitals and were promoted to urban centers if they did well.

At about the same time I was forced by budget limits to refer patients to NP hospitals for psychiatric care, the Hospital Director at the only VA long term psychiatric hospital in the state called to report that he could improve his hospital's budget by converting long term psychiatric beds to "Intermediate Medicine" beds (i.e., the same patient receiving the same care in the same bed earned more money if it was called a "medicine bed" than if it was called a "psychiatric bed").

The VA NP Hospital Director noted that long term patients were aging and could be cared for identically in this "recategorized" bed unit. He promised to continue to accept those patients we referred, saying that the recharacterization was in name only (i.e., a budget game) and that nothing would really change.

As a result of this commitment to continue to accept our patients, our Hospital Director supported this request to change the designation of beds. Within six months, however, the NP hospital routinely refused our psychiatric referrals, thus the improving the finances of the NP hospital but depriving psychiatric patients of an important treatment option.

From 1979 through 1986, I worked in the Mental Health and Behavioral Sciences Service. During that time, the VA Central Office developed a new resource allocation methodology (RAM) whose explicit purpose was to make the VA more like the private sector by using a budget based on episodes of care.

"Episodes" were described by a category system which lumped diagnoses together into related groups (DRGs), as in the Medicare system's DRG payment methodology. VA leadership simultaneously wanted to reduce the large budget expenditures devoted to long term care in medicine and psychiatry.

Ironically, when the early trial runs of this more objective method of budgeting were reviewed, large amounts of money shifted from tertiary care medical and surgical hospitals to psychiatric hospitals because psychiatric hospitals provided more episodes of care at less cost. It required many "adjustments" to the early RAM model to make sure that the highly affiliated tertiary care medical and surgical hospitals were not severely "penalized" by the cost-effectiveness of psychiatric services. The modified RAM approach was subsequently adopted and has had a variety of effects, both positive and otherwise.

Over the past few years, VA has made continuing efforts to find a budgeting tool that was credible to the hospitals, to the Office of Management and Budget, and to the Congress and that also fostered realistic discussion about budget and workload concerns. In my judgment, the basic budget principle should be that lower budgets will generally support less output and higher budgets will support increased output. Assuming that an allowance is made for weighting to account for quality as part of the assessment of workload, this principle should work very well.

So far, in my view, VA efforts demonstrate good intentions but only limited results. The newest approach—called the Resource Planning Methodology (RPM)—uses data and assumptions which will maintain many of the historical failures of our budgeting system. However the largest problem with all of these methods to date is that they distribute what is simply an inadequate amount of money.

IV. IMPLICATIONS OF CURRENT VA POLICY ON TREATMENT

As Congress and the President grapple with the budget deficit, the Department of Veterans Affairs—as does every other Federal Agency and program—faces hard times today. As the economy drifts, more and more veterans require psychiatric services. Because insurance coverage for mental illness discriminates against the mentally ill by setting life-time limits on hospital days, outpatient visits, and total costs, our veterans must seek treatment in the VA medical system.

Despite high occupancy rates and what I believe will be continued high and increasing demand, the VA has reduced its active psychiatric inpatient beds by about one thousand beds per year throughout my career in the agency. At the same time, medicine and surgery beds in many parts of the country have been running far below reasonable occupancy rates, but they have not been substantially reduced.

In addition, relative staffing rates have improved in medicine and surgery because of these occupancy rate changes, while improvements in psychiatry have not occurred. In simple terms, staffing ratios for surgery and medicine beds have improved because fewer of these beds are occupied, while staffing ratios for psychiatric beds have not improved because these beds have much higher occupancy rates. Currently, we operate less than twenty thousand beds, and I fear that we are slowly being forced in a downward direction because of the sharp differences between how we provide psychiatric care and other kinds of medical care.

The mission statement of the VA has been to provide quality care which is "second to none". Overall, the VA has been able to provide this level of care in most of our medical and surgical services most of the time. Although adversely affected

by lean staffing, our medical and surgical programs continue to offer highly sophisticated care to most patients. In the affiliated programs, the quality of care compares very well with the quality of care provided at the university affiliate. In psychiatry, unfortunately, the quality of care has been far more variable.

One of the most basic indicators of the ability to provide quality care is the number of doctors available to treat the patients. The physician/patient ratio in psychiatry varies dramatically from VAMC to VAMC, with the large NP hospitals having the worst ratios. At Perry Point, inpatient physicians are frequently responsible for the total care of between 15 and 40 patients. In some other hospitals, a physician may be responsible for as many as 50 patients.

Similar ratios apply in outpatient settings. The average outpatient medical visit lasts about fifteen minutes. As a good standard of care, psychiatric outpatient visits need to be longer than that yet in my outpatient clinic many patients get only ten minutes. I note that the "standard" duration of most individual psychotherapy outside the VA system is 45-50 minutes in duration, or roughly five times as long as what is offered inside the system. The number of follow-up visits per year in VA psychiatry often is limited to two or three, when four to six visits per year ought to be a minimum.

Perhaps the most important difference in staff to patient ratios can be best understood by examining the usual schedule of VA psychiatrists and internists in our highly affiliated settings, where research and education are active parts of the daily work expectation.

In non-psychiatric medicine, staff physicians expect to spend time supervising residents and medical students, lecturing, working in clinic, and seeing patients in clinic. These physicians rarely expect to have substantial direct personal responsibility for the day to day admission, treatment, and discharge of patients. In contrast, VA psychiatrists routinely expect to spend as much as eighty percent of their time in direct patient care because there is no one else to treat the patients.

The direct effect of this difference can be seen in two important ways. First, when recruiting new staff, many choose to go outside psychiatry if they have any academic potential. Second, VA psychiatrists have much less time available to formulate research ideas, develop grant proposals, or conduct research. This is the major reason that VA's investigator initiated research process awards so few grants to psychiatric research. In other words, VA psychiatrists have far greater amounts of direct clinical responsibility than our non-psychiatrist medical colleagues.

An extensive analysis of physician staffing conducted for the VA by the National Academy of Science in 1991 documents the substantial differences between medicine and psychiatry both across VA facilities and between the VA and other systems. VA medicine and surgery are roughly comparable to other systems while VA psychiatry falls far behind.

I believe that changes in how the VA staffs its mental health programs and the development of targeted research in clinical and basic science of mental illness will begin to provide the very high percentage of VA's psychiatric patients with appropriate levels of clinical care and research investment. MIRECCs will be a strong and effective first step.

V. POLICY ALTERNATIVES

If VA plans to bring its psychiatric care up to the standards of the excellent programs which exist around the country there will need to be revisions in how we think about staffing levels for psychiatrists and other non-physician mental health providers inside the VA system.

At my hospital, we have gradually reduced beds in order to make some accommodation for our staffing levels. If staffing levels improved, several important changes in approach become practical and desirable.

First, in my view, it will be important to provide enough acute and long term psychiatric beds in every "Primary service area" (PSA) to meet the local needs for open or locked unit care. Patients who will need long term care or locked ward care should not be moved miles away from their neighborhoods for treatment because re-entry becomes so much harder.

The most severely ill patients who need protracted hospital services (often service connected veterans with schizophrenia) should be placed in well staffed units which can devote the time and effort required to permit them to achieve optimal levels of independence. When treatment resources are minimal, outcomes are usually minimal.

Second, there must be a shift in emphasis to permit continuity of care from the outpatient clinic through the hospital and back to the outpatient clinic. Severely ill psychiatric patients have better prognoses when they can turn to a single provider

(commonly called a case manager) for advice, support, and assistance before they need to be admitted for treatment. This kind of continuity of care must be based in the same community as the patient, otherwise, ease of access and similar logistical issues will diminish the ability of the case manager to help the patient maintain an independent way of life.

This change will drastically alter the behavior of many of the urban tertiary care medical centers by requiring them to accept the responsibility for more of the care of chronic patients. The only alternative to this plan might be to empower the long term VA psychiatric hospitals to base members of their staff at the tertiary care hospitals to work with patients and the treatment teams to maintain continuity of care.

If the VA adopts these changes, e.g., suitable staffing levels for psychiatric care, a case management model for chronic patients, and acceptance of psychiatric patients as one of the central responsibilities of the VA, then the sensible division of resources will put mental health care on an equal footing with other kinds of medical care. Such a shift can be identified by improvements in the psychiatric staff to patient ratio and by increases in the activity of VA psychiatrists and other mental health staff in research and education activities.

VI. CONGRESSIONAL RESPONSES

In the past, several approaches have been taken to solving the many problems in the VA's treatment of psychiatric patients. When new policies have been mandated by Congress, the VA has sometimes resisted them because the mandates are perceived as limiting the flexibility of hospital managers to make decisions which, in their professional judgment, best addressed the specific requirements applicable to their individual facilities.

At the same time, when the VA has pledged general improvements as an alternative to perceived "micromanaging", the results have depended significantly on the ability of officials of understaffed programs to protect their individual programs against general erosion caused by fiscal problems facing most VA hospitals.

Clearly, Congressional oversight has helped limit further erosion in mental health care and has pushed the VA to improve care in PTSD, substance abuse, and a small number of long term psychiatry pilot projects. More remains to be done. Even though most medical centers in the VA see a need for improved approaches to acute and long term psychiatric care (including chronic mental illness and dementia groups), few facilities want to stop doing other kinds of valuable care to meet these needs.

I recognize that there is great pressure on Congress to respond to local constituent concerns that may be generated as the VA reallocates existing funds among medical disciplines. I hope, however, that Congress will also continue to recognize that the overriding issue is how we can best ensure that the specific needs of VA patients are properly addressed, since it is the patients who are our mutual constituents and who deserve the best possible care.

In this respect, I think we need to take steps to ensure a more appropriate balance between particular patient needs and available dollars within the VA system. Sadly, today, although psychiatric patients make up over 33% of all VA inpatients at any given time, psychiatric care receives less than 15% of total inpatient dollars.

When decisions are approached from the perspective that patient needs must be the most important factor, improvements in psychiatric care inevitably receive a very high priority. Yet stigma associated both with mental illness and particularly with geriatric psychiatry patients often overrides proper allocation of resources based on patient care needs. Congress can play a critical role in ensuring that program budget allocations are based on need, not on stigma and ignorance.

In response to the pending legislation, I would like to express the American Psychiatric Association's strong support of the VA's efforts to provide treatment for combat veterans and others with Post-Traumatic Stress Disorder. Existing programs provided by the Mental Health and Behavioral Sciences Service and the Readjustment and Counseling Service are important and necessary.

Funding for VA psychiatric research in the VA has remained vastly disproportionate to the utilization of psychiatric services. While psychiatric problems account for about 40% of inpatient days in VA medical centers, funding for behavioral research has never matched that percentage of the total Medical research budget. Research is vital to our understanding to the causes and treatment of mental illnesses.

The APA believes that the Mental Illness and Research Clinical Centers (MIRECCs) will provide an important opportunity to advance both treatment and research efforts in mental illness. The establishment of MIRECCs with a strong clinical base will draw valuable participation from affiliated institutions and benefit

veterans for decades to come. The APA is pleased to support the Chairman's proposed legislation and looks forward to working with you towards enactment and funding for MIRECCs.

Mr. Chairman and Members of the Committee, on behalf of the American Psychiatric Association, I commend you for your leadership and continued commitment to improving mental health care for veterans. APA is also very encouraged by the fact that the new Administration has begun to take a serious look at these issues. I look forward to working with you to ensure that VA's programs for the treatment and rehabilitation of mentally ill veterans, especially in outreach, clinical care, and research, receive a higher priority.

PREPARED STATEMENT OF DR. PATRICIA B. SUTKER, CHIEF PSYCHOLOGIST, PSYCHOLOGY SERVICE, NEW ORLEANS VA MEDICAL CENTER

INTEGRATED MENTAL HEALTH PROGRAM FOR WAR-RELATED PSYCHOPATHOLOGY: ASSESSMENT AND TREATMENT OF THREE GENERATIONS OF COMBAT VETERANS

I. PROGRAM RATIONALE. Within the past decade, it has become better understood that the predictable mental health outcomes of military combat among men and women are elevated levels of psychological distress, often accompanied by frequent somatic complaints and problems in cognitive functioning. As the severity of combat exposure becomes more prolonged and horrific, the emergence of war-related psychopathology, or disorders such as post-traumatic stress disorder (PTSD), is increased. Data collected nationwide among Vietnam theater veterans revealed current and lifetime rates of war-related PTSD in 15% and 31%, respectively, and although rates of psychopathology among World War II (WWII) and Korean conflict (KC) combat veterans are not readily available, except among POW survivors of these wars, rates of war-related psychopathology have been documented in almost one-fourth of a large sample of nontreatment-seeking Persian Gulf deployed troops. Given knowledge of the inevitability of negative mental health outcomes to war among sizable subsets of veterans, VA Central Office leaders, specifically, Drs. Paul Errera and Laurent Lehmann of Mental Health and Behavioral Sciences Service, waged a successful campaign to establish a nationwide network of treatment services targeted to the psychopathology that resulted directly from military duty. Our Medical Center has received support for a multimodal program for assessment and treatment of war-related psychopathology.

II. PROGRAM ACCOMPLISHMENTS. We have implemented four mental health initiatives targeting combat veterans of WWI, KC, Vietnam, and the Persian Gulf War in the past four years, and a fifth component addressing gender-specific needs is being developed. As components were added, the organizational system achieved coordinated service delivery of outreach, education, multidisciplinary assessment including neuropsychological evaluation, crisis intervention, therapeutic interventions including pharmacotherapy, and planned follow-up services. Honored by the Friend of the Vietnam Veterans of America Award in 1993, the program is composed of five components:

(A) PTSD Clinical Team (PCT): Established in 1989 to provide outpatient mental health services to veterans of all military operations characterized by PTSD and other war-related psychopathology; ranked first nationwide in numbers of veterans served in FY 1992 and the first half of FY 1993.

(B) Substance Use/PTSD Team (SUPT): One of nine established in 1991 to provide services to veterans characterized by dual diagnoses of PTSD and substance abuse disorders; ranked first nationwide in total number of veterans enrolled and number of new veterans enrolled in the last quarterly reporting period.

(C) Evaluation Brief Treatment PTSD United (EBPTU): A 10-bed program opened in mid-1992 offering intensive 6-week therapeutic milieu and requiring sustained commitment among veteran patients; staffed by 8.5 FTEE and enrolled 114 veterans to date.

(D) Operation Desert Storm (ODS) Evaluation, Debriefing, and Treatment Team: Initiated in 1991, provided debriefing and psychological assessment services to 493 National Guard and 930 reserve troops at regularly-scheduled drill exercises timed 6, 8, and 12 months subsequent to ODS; conducted 288 one-year follow-up evaluations, repeating initial psychological assessment and debriefing exercises; provided treatment services to 93 ODS veterans.

(E) Women Veterans Stress Disorder Treatment Team: Planned for 1994, targets women who served in military operations and is an outgrowth of recognition of women's involvement in war trauma and an historical lack of attention

to the needs of women veterans within our Medical Centers. Data from ODS troops in Louisiana show the 14% are women, and this sizable percentage of female troops signals the need for programs to implement adjustments and expansion to meet the demands of the changing military population.

PREPARED STATEMENT OF DR. CHARLES P. O'BRIEN, CHIEF OF
PSYCHIATRY, PHILADELPHIA VA MEDICAL CENTER

Good morning Mr. Chairman. I am Charles O'Brien, Chief of Psychiatry at the Philadelphia VA. I have observed the toll taken by substance abuse and other mental disorders while on active duty as a U.S. Navy physician and as a VA physician for the past 22 years. These problems are very severe among the population of veterans coming for help at our VA Medical Center in Philadelphia. On any given day more than 50% of the patients on our medical and surgical wards are being treated for complications of some form of substance abuse, either nicotine dependence, alcohol dependence, cocaine, or heroin dependence. It seems that among U.S. military veterans, those suffering from mental disorders including substance abuse are more likely to seek care in a VA facility than those who are mentally healthy and likely to be covered by private health insurance. Many of our patients suffer from substance abuse in combination with other psychiatric disorders such as Schizophrenia, Depression or Post-traumatic Stress Disorder.

A gradually increasingly proportion of our patients are in the geriatric age group and among our aging veterans, there is a very high frequency of behavior disorders. These include the complications of aging such as Alzheimer's disease, as well as psychiatric disorders that begin in youth and continue into the senior years. Thus, our Psychiatry Service has to expend much of its resources taking care of the emotional problems of elderly veterans in our Nursing Home. Our psychiatric beds are almost always full and thus we are forced to search for non-VA beds in the community or to treat potentially dangerous or suicidal patients as outpatients. We serve approximately 130,000 outpatient visits per year which is about half of all outpatient visits for the Medical Center.

The VA has a proud history of research accomplishments. Many of our current treatment sin cardiology, gastroenterology and surgery have been developed through VA collaborative studies. In the psychiatric field, many of the important anti-psychotic medications were developed in VA studies. In the area of substance abuse, two medications approved by the FDA for the treatment of opiate dependence have been developed because of major contributions by VA research. Our research has developed the major measuring scale for addiction that is now being used not only throughout the VA, but also throughout the United States and many foreign countries. New treatments for alcoholism, for opiate dependence and for cocaine dependence have been pioneered by our VA research program. Today, however, there are few VA medical centers where psychiatrists are engaged in research. There are simply not enough staff psychiatrists, psychiatric residents and psychiatric beds to take care of the huge number of veterans with psychiatric problems. Thus the exhausting demands of providing urgently needed care make it very difficult for psychiatric physicians to write research proposals and conduct medical research. This makes recruiting psychiatrists to the VA much more difficult. Clearly we should direct resources toward the treatment of mental disorders including substance abuse in proportion to the needs of the veteran population.

Thank you for the opportunity to discuss the problems of our veterans population in the mental health area.

PREPARED STATEMENT OF RICHARD T. GREER, MEMBER, SCIENCE
REVIEW COMMITTEE, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Thank you Mr. Chairman. My name is Richard T. Greer and I am a veteran of World War II. I have a son who is disabled by mental illness. Since retiring from the Senate as a Subcommittee Staff Director on the Senate Energy & Natural Resources Committee, I have been Director of Government Relations and, currently, a volunteer advocate for the National Alliance for the Mentally Ill (NAMI). On behalf of NAMI's 140,000 member families, I convey our appreciation to you for scheduling this oversight hearing concerning programs involving the mentally ill veterans.

A substantial portion of the VA health budget is devoted to treatment of veterans with mental illness. There is apprehension among our 1,000 National Affiliates, NAMI's Veterans' Network, as among all of us here today, about how the Depart-

ment of Veterans Affairs (VA) medical programs will fare in changed relationships to mainstream health care under a newly reformed national system.

Before national health care reform becomes a reality, however, there are things that VA must do. NAMI has concerns about these. They include clinical research on diseases of the brain, services research on how better to deliver the package of supports that truly rehabilitate, and efforts to deliver such coordinated services packages even as such research continues.

I. CONTINUING VA PSYCHIATRIC RESEARCH IS CRITICAL

Mr. Chairman, for the VA to reduce its commitment to psychiatric research, as proposed by the Administration, would be penny-wise and pound-foolish. Research on schizophrenia and manic-depressive illness shows great promise at this time. Within the past 10 years there has been an outpouring of research data showing that these diseases are brain diseases in exactly the same way that Alzheimer's disease, Parkinson's disease, and multiple sclerosis are brain diseases. We have never before had the opportunity which we now have to make major breakthroughs in understanding, treating and eventually preventing diseases such as schizophrenia and manic-depressive illness.

Compared with other areas of VA medical research, the investigation being done by VA scientists on schizophrenia and manic-depressive illness is perhaps the strongest research being done by the Department. Given the high percentage of VA beds occupied by veterans with these illnesses, this is as it should be. Because VA research is an integral part, and an important part, of the nation's overall research efforts on schizophrenia and manic-depressive illness, the effects of the currently proposed VA research reductions will be felt by all scientists in the research field. Therefore, NAMI has strongly endorsed increased appropriations for such research.

In this regard, I point out that the FY 1994 VA-HUD-Ind Agencies Appropriations Bill (H.R. 2491; H. Rpt. 103-150) passed the House on June 29. Based on NAMI's recommendation, the Report contains the following language:

The Committee recommends that the Research Review Committee, covering psychiatric research for the Department of Veterans Affairs (VA) and for the National Institute for Mental Health (NIMH), conduct joint meetings and submit a report outlining ways and means to improve the coordination of psychiatric research between the two federal agencies. Specifically the report should address the issue as to whether the use of beds in VA hospitals might be utilized more for NIMH clinical studies in order to reduce the overall cost of such studies. This report is to be transmitted to the Committee prior to the fiscal year 1995 budget hearings.

NAMI believes that the proposed "Mental Illness Research, Education, and Clinical Centers" bill drafted by Senator Rockefeller is a constructive move in the right direction, and is pleased to endorse it.

II. NEED FOR VA RESEARCH ON COMMUNITY-BASED SERVICES

Research to understand how the current VA system performs and what is needed to improve it must be authorized in order to provide the foundation for managing change in the veterans' health care system. The only way that the VA can meet the urgent twin goals of quality care and cost containment is to identify what delivery systems are most effective and what treatments work best for whom.

Collaboration With NIMH

The VA could take advantage of closer linkages with the NIMH services research programs. The rapid build-up of these NIMH programs—from \$17 million in FY 1987 to \$47 million in FY 1992 (not including resources at CMHS)—demonstrates the priority emphasis on research of community-based treatment for the severely mentally ill including programs to assist successful transition of long-term hospital patients into their own communities.

The VA mental health system is still heavily hospital-oriented, and the NIMH program is not. It is NAMI's understanding that currently there is only one joint-funded project between NIMH and the VA, and only two researchers. This is just not enough to provide the data necessary to solve these problems.

NAMI strongly recommends that the Committee consider the utility of more effective communication and collaboration between the VA and NIMH in clinical research, and services research—toward independent living.

Research on Services Provides Answers

Mr. Chairman, the VA spends over \$3 billion on benefits, treatment and services for severely mentally ill veterans.

Therefore, Mr. Chairman, NAMI respectfully suggests that Senator Rockefeller's proposal can build on this by authorizing specific research programs which include, not only clinical studies, but also health services research. The parameters of the programs would include observations of best practice both within and outside the VA system.

NAMI urges the Committee to include an agenda for health services research responsive to the needs of veterans; and one that can assure that the information needs required to improve the delivery of community-based long term care, will be available in the future to policymakers, managers, clinicians, and volunteers.

III. VA DEVELOPMENT OF COMMUNITY-BASED SERVICE DELIVERY CAPACITY

Existing, Well-Researched Model from NIMH

NAMI believes that the mental illness field knows quite well what kind of services work to rehabilitate persons with severe mental illness and to maintain them in stable condition, living independently in the community. VA must investigate and replicate this model, as an acknowledgement that state-of-the-art care for persons with severe mental illness is no longer hospital-based.

MMH has carefully studied an assertive community treatment program for more than a decade. Without dissension, all acknowledge its superior outcomes. The aggressive NIMH approach to symptom reduction and prevention of relapse was also designed to foster independent living and improve the quality of life of clients and their families. Over time, the concept came to be known as the Program in Assertive Community Treatment (PACT).

Research has been a hallmark of PACT development. The initial Wisconsin PACT was designed as a randomized trial, allowing a comparison of outcomes for PACT clients with those for clients receiving the usual hospital and aftercare services. This exemplary, but highly unusual approach to developing new services demonstrated benefits in independent living, social functioning, and employment status, as well as lower use of hospital inpatient services.

A set of clinical trials involving PACT now provides the strongest research evidence available for any services program for persons with chronic psychotic disorders. Further, it is the only full services program for persons with severe mental illness that has been tested in multiple clinical trials. Moreover, a number of clinical trials currently supported by NIMH and CMHS will allow better opportunities to assess outcomes and to test the usefulness of PACT for subgroups of patients by diagnosis, gender, and race.

Sharing Findings With Service Delivery Staff

Mechanisms to facilitate greater collaboration between service delivery systems personnel and researchers should be encouraged. While the Public-Academic Liaison (PAL) program could be an important mechanism, it is directed to individual projects and not to the stimulation of a continuing collaboration.

NAMI recommends for VA purposes, that development of long-term collaborative arrangements be encouraged between NIMH-based research in PACT and VA service systems personnel.

Voluntary Community Support Is Critical to Long-Term Care

Total, continuing, and cost effective health care for veterans with mental illness will be shaped by various factors including the structure of health insurance, housing, and social services regulated by various levels of government. In addition, voluntary programs dedicated to improving the quality of life for psychiatrically disabled veterans can prevent what often becomes an irrevocable break in the continuum of health care for some of these veterans. Effective mental health services require a full understanding of these community support programs. Family members are an important resource in the treatment of severe mental illness. Research overwhelmingly shows that when families are informed and take an active part in treatment decisions, consumer outcomes are better.

In the case of veterans, an "adoptive family advocacy" concept needs to be encouraged. The mentally ill veteran receiving disability benefits frequently will have funds with which to obtain services, but for various reasons cannot become integrated into a community mental health system. In these circumstances—or where the mental health system is understaffed, underfinanced, services uncoordinated, or other problems impede proper service delivery and integration into the community—the adoptive family's involvement and advocacy is essential to assure the best possible treatment.

NAMI recommends a study of the community support auxiliary concept, using programs which have been shown to be effective, e.g., the Bay Pines project, as models for implementation.

Role of the Vet Centers

In this regard, Mr. Chairman, NAMI appreciates S. 1226, Senator Akaka's bill to upgrade some 200 "Vet Centers." The Centers should be surveyed regarding their needs and desires for linkages to community auxiliary organizations. After assessing the Centers' responses to such a survey, NAMI would devote full attention to working with our local Alliances in those areas, along with officials of the VA, NIMH, and CMHS, in an effort to meet the Centers' identified needs and preferences for auxiliary assistance.

NAMI recommends the legislation include a study to determine what the various centers would like to see in the way of a community support auxiliary program as an adjunct to their long-term care programs.

RELATIONSHIP TO HEALTH CARE REFORM

Mr. Chairman, when the Committee eventually drafts legislation to relate veterans' health care to the overall reform package, it will still have to give high priority to veterans with mental illness for at least two reasons.

(1) The VA medical system fulfills a long-standing national commitment to veterans and has no counterpart in the private sector that can provide self-contained comprehensive care.

(2) President Clinton signed an Executive Order May 19, 1993 calling for development of a coordinated federal plan to break the cycle of homelessness. A significant percentage of the homeless are veterans with mental illness. The VA has its network of medical centers, and through these has the potential to work with and develop creative local programs to end homelessness.

Mr. Chairman, Senator Rockefeller's bill on "Mental Illness Research, Education, and Clinical Centers," could provide the foundation for managing change in the veterans' health care system prompted by relationships to national health reform.

COST OF PSYCHIATRIC DISORDERS

Psychiatric disorders are extremely expensive for the VA, yet we are aware of no adequate programs to bring the veterans with mental illness back into productive community life. Expenditures for VA mental health for the current fiscal year are \$1.3 billion.¹ Of this, at least \$865 million is being spent on mental health services for veterans with schizophrenia and manic-depressive illness (also known as bipolar disorder).² Thus, these two diseases alone require approximately two-thirds of the VA budget for mental health services because those afflicted are often substantially disabled and utilize a disproportionate share of inpatient and outpatient resources.

In addition to the VA mental health services budget, the VA also pays benefits to veterans with "service-connected" disabilities. The number of veterans currently receiving benefits for psychiatric disabilities, as of April 1993, includes the following:

Diagnosis	Number of veterans receiving benefits	Number who are receiving 100% disability benefits	Percent of total who are receiving 100% disability benefits
Schizophrenia	99,455	50,491	51
Other psychotic disorders (including manic-depressive illness)	15,743	4,246	27
Post-traumatic stress disorder	50,978	7,627	15
Anxiety neurosis	132,554	9,900	8
Depressive neurosis	19,308	2,707	14
Other neuroses	28,813	1,778	6
Total	346,851	76,749	22

¹Memorandum from Director, Mental Health and Behavioral Sciences Service, Department of Veterans Affairs, April 22, 1993.

²Wyatt, R.J., de Saint Ghislain, I., Leary, M.C., and Taylor, E. An economic evaluation of schizophrenia, 1991. Submitted to *Hospital and Community Psychiatry*, 1993. The \$865 million includes inpatient, outpatient, and intermediate/domiciliary VA care for veterans diagnosed with schizophrenia and manic-depressive illness.

Schizophrenia and manic-depressive illness (which comprises the majority of "other psychotic disorders") together account for 71 percent of all veterans who are currently receiving 100 percent disability benefits for psychiatric disorders. Currently a veteran with 100 percent service-connected disability receives a minimum of \$20,000 per year (depending on length of service, number of dependents, and other factors).

The total annual cost for VA disability benefits for schizophrenia and manic-depressive illness alone is approximately \$1.1 billion for those receiving 100 percent disability. If it is assumed that the other (than 100 percent) beneficiaries average 50 percent disability, an additional \$700 million in VA disability payments would be required. Total annual VA disability payments for schizophrenia and manic-depressive illness may therefore total approximately \$1.8 billion.

Add these to the cost of treatments and you can appreciate that aggregate VA outlays for veterans with schizophrenia and manic-depressive disorder alone total over \$3 billion. Yet precious little is spent on learning how to provide care more efficiently and effectively. Mr. Chairman, when the Senators meet to mark-up provisions of Senator Rockefeller's "Mental Illness Research, Education, and Clinical Centers" bill, these statistics should be borne in mind.

NEED FOR NEW LEGISLATION

At present, the VA has no clear statutory authority to provide long term services to other than service-connected veterans. Availability of resources at individual medical centers determines the capacity for delivering long term services, rather than needs of the veteran population. Also, only a few medical centers provide a full continuum of community-based services.

Social support services, so vital to the mentally ill, are usually arranged by referral to services outside the VA system, such as the Suncoast Community Support Auxiliary,³ an affiliate of NAMI.

Mr. Chairman, because of the location of its facilities and the singular nature of its existing patient population, the VA starts out at a considerable disadvantage in either the delivery of, or the arrangement for the delivery of, the kinds of social support services so vital to the mentally ill.

However, I can assure you that NAMI is prepared to help level the playing field by utilizing the Bay Pines/Suncoast Community Support concept in cooperation with, not only the VA psychiatric hospitals, but also the "Vet Centers" around the country.

In particular, Mr. Chairman, NAMI does have four specific recommendations with respect to Senator Rockefeller's bill:

Page 3, line 12 (4)(A) should read: . . . so as to provide such residents with research training opportunities as well as training in the diagnosis and treatment of mental illness;

Page 3, line 14 (4)(A) after the word "illness" strike the semi-colon and add: for the purpose of (1) improving the system of psychiatric care at that medical center, and (2) for conducting an evaluation study, or series of studies, that would document the implementation of the proposed improvements and their impact on the care of veterans;

Page 3, line 15 (4)(B) should read: an arrangement with a graduate school of psychology accredited by the American Psychological Association . . .

Page 4, line 16 (4)(F) strike "of the center" and include: to improve care at the center and to conduct empirical research on the implementation and measurement of service systems change.

MENTALLY DISABLED INCOMPETENT VETERANS

Mr. Chairman, there is a final issue that has been very important to NAMI, and in which we've taken an active role. It is not on the call of the chair for this hearing. But we would be remiss if we did not bring it to your attention.

While it is particularly gratifying to see the 103rd Congress' concern for the mentally ill veteran, first in the House and now in the Senate, the mentally disabled incompetent veterans have still not been made whole. You will recall the mentally disabled incompetent veteran was the subject of Section 3205 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). This section of the Act eliminated the earned disability incomes of some 11,000 mentally disabled incompetent veterans.

The mentally disabled incompetent veterans are a very special part of the larger group of mentally ill veterans. The reason for particular concern about the mentally

³ See addendum regarding Suncoast Community Support Auxiliary.

incompetent (as defined by the Department of Veterans Affairs) disabled veteran is because they are not in hospitals but out in our communities. Moreover, with the help of family, friends, and/or financial counselors—they have established estates of \$25,000 or more—and are trying to make it on their own.

Mr. Chairman, I am sure you will recall that OBRA required cuts in the VA to achieve a \$3.35 billion net reduction over the 5-year period of the agreement. One way to do this the Congress determined, was to arbitrarily cancel earned compensation of certain mentally disabled incompetent veterans. Hidden in Section 3205 of the huge budget reconciliation bill, the provision went through so easily and unnoticed that the Bush Administration proposed in the Fiscal Year 1992 Budget to make the withholding permanent.

The budget proposal for targeting this vulnerable population was based on the rationale that the withholding would reduce "fiduciary abuse" and produce "savings" of an estimated \$250 million. However, I am pleased to report that NAMI and the Disabled American Veterans (DAV) joined forces successfully—initiating litigation and working with Congress—to defeat the ill-advised concept.

In support of the DAV action, NAMI submitted an Amicus Brief not only on behalf of itself but also for the National Mental Health Association, the American Psychiatric Association, and the Mental Health Law Project. NAMI emphasized in its Brief:

By requiring Incompetent Veterans to "spend down" their estates to less than \$10,000 in order to have their disability compensation benefits restored, Congress has apparently made the judgment that mentally incompetent veterans should not similarly be protected from destitution caused by catastrophic, disability related circumstances. At a time when homelessness among veterans who are mentally incompetent has become a national dilemma, this is an irrational way for the federal government to save a relatively small amount of money for the federal fisc.

In the face of mounting pressure from Congress, the Department of Justice finally announced that the Government would agree to forego reimbursement and continue full disability payments to all mentally disabled incompetent veterans, if the DAV would withdraw their lawsuit. U.S. District Court Judge Shirley Wohl Kram, early this year, approved a settlement that restored regular payments plus approximately \$75 million in benefits while the DAV and the class dropped their lawsuit.

Mr. Chairman, NAMI feels it is imperative to clear the air on this issue in closing our prepared testimony—and point out—that, although the aforementioned victory is a heartwarming and gratifying one, it is one which in no way should preclude full reimbursement, whether by a special appropriation or from an existing Departmental discretionary fund. It is estimated that the government still owes these veterans \$175 million in withheld benefits prior to Jan. 31, 1992. I am sure the Congressional Budget Office can provide you with the exact figure. Common sense and equity demand full reimbursement.

NAMI respectfully suggests that the Committee include provisions in Senator Rockefeller's bill to authorize reimbursement for the balance due to these 11,000 mentally disabled incompetent veterans.

Thank you, Mr. Chairman and members of the Committee for your attention and concern.

DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Doug Hall, Bay Pines VA Medical Center CSG Coordinator nominated *Suncoast Community Support Auxiliary, Inc.* for President Bush's "Thousand Points of Light Award and Recognition," January 1993, as follows . . .

Introduction

The Suncoast Community Support Auxiliary, Inc. (SCSA) is a non-profit charitable and educational organization dedicated to improving the quality of life of psychiatrically disabled persons and their families. SCSA began in 1985 as a group of family members of veterans in the Community Support Group (CSG) Program at the Bay Pines VA Medical Center who met with staff to discuss the ramifications of mental illness within families. Family members pooled their resources, volunteered to help and in 1987 incorporated under state law as a charitable non-profit organization. Today the Auxiliary has a membership of over 90 individuals and families. The Auxiliary is recognized as a volunteer organization by Bay Pines Voluntary Service and is affiliated with the National Alliance for the Mentally III

(NAMI). The Auxiliary is funded by voluntary dues and support of the CSG and veterans in the community.

Achievement

SCSA publishes a monthly newsletter on mental health topics. Now in its 86th issue, the newsletter contains articles by staff, consumers, and family members to educate, inform and enhance communication between consumers, families and staff. SCSA maintains an extensive mailing list and sends out over 400 newsletters each month.

The SCSA Visitation Program provides social and recreational activities for veterans in the hospital and the community.

The SCSA Telephone Committee provides the simple but crucial service of telephoning consumers, families and others to convey important information quickly, respond to urgent needs of CSG members, and recruit volunteers for various CSG activities.

The SCSA annually organizes a banquet and graduation ceremony for graduates of CSG's independent living skills classes. Graduates are given diplomas and awards for meritorious achievement.

The Annual CSG Picnic and the Winter Party are joint efforts of SCSA and CSG consumers. Approximately 200 consumers, family members, VA staff and persons from the community attend each of these events annually.

A major long term goal of the Auxiliary is the establishment of a community Drop-In Center for CSG veterans. A large portion of the Auxiliary's donations and annual dues is held in reserve as seed money for the Drop-In Center.

Community Needs

Chronic mental illness is highly stigmatizing and debilitating affecting the entire family and the community. Persons with chronic mental illnesses need supportive services in addition to psychiatric treatment to live and function in the community with dignity. Families need information, support, and opportunities to participate effectively and appropriately in the treatment of mentally ill family members. Through its social, educational and networking activities, the SCSA helps meet these needs for veterans and their families.

Innovation

SCSA is unique: a voluntary association of veterans and family members organized to support and enhance a mental health treatment program. SCSA brings together veterans, families, and VA staff in a cooperative effort to promote mutual understanding and high quality services. SCSA provides a vital supplement to the limited resources of the CSG.

Mobilization

SCSA is continually striving to expand its services and provide opportunities for others to volunteer. New members and volunteers are always welcome and encouraged to be as active as possible.

Ongoing Involvement

Started in 1985, SCSA is still going strong today and looking to the future. SCSA's activities are carried on throughout the year and SCSA members are in continuous contact with consumers, families, and staff.

Department of Veterans Affairs

PSYCHIATRY SERVICE

Certificate of Appreciation

Presented to

SUNCOAST COMMUNITY SUPPORT AUXILIARY, INC.

This award is presented by Psychiatry Service, Bay Pines VA Medical Center, to the members of the Suncoast Community Support Auxiliary, Inc. in recognition of their selfless dedication and invaluable contributions to the veterans within Psychiatry Service.

Through its monthly newsletter, visitation program, telephone committee, and graduation banquet, but mainly through the tireless devotion and generosity of its members, the Auxiliary provides a vital supplement to the limited resources of the Community Support Group. Without their efforts our program would not be as successful as it has been.

For approximately 8 years the Community Support Auxiliary, with their cooperative effort, has brought together veterans, families and VA staff to provide mutual understanding and a high quality of mental health care to veterans in Psychiatry Service.

Ali Keskiner, M.D.

Ali Keskiner, M.D.
Chief, Psychiatry Service

May, 1993



PREPARED STATEMENT OF HERSHEL GOBER, DEPUTY SECRETARY OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, I am pleased to be here to discuss the Department's efforts to care for veterans suffering from chronic mental illnesses. Before discussing VA's mental health programs I will present the Department's views on two pieces of legislation, Senator Akaka's bill pertaining to our Readjustment Counseling Vet Centers, and your draft bill, Mr. Chairman, which directs that we establish five centers for mental illness, research and education.

S. 1226—READJUSTMENT COUNSELING

Mr. Chairman, Senator Akaka's bill, S. 1226, contains a number of different provisions affecting the Readjustment Counseling Service, and the Vet Centers through which we provide counseling services. We generally support, in whole or in part, most of the provisions of the bill. However, we are concerned about the requirement that we conduct a pilot program to furnish outpatient care through Vet Centers.

Organization of the Readjustment Counseling Service

Section 2 of the bill is aimed at preserving the existing organizational and administrative structure of the Readjustment Counseling Service. As you know, the Department provides readjustment counseling services through unique entities known as Vet Centers, community-based facilities that have been very successful at meeting the needs of Vietnam and post-Vietnam era war zone veterans. Vet Centers work closely with local VA medical centers, but they are administered independently from those centers. Senator Akaka's bill seeks to insure the continuance of that independence.

The bill would statutorily establish the current organizational and administrative structure of the Readjustment Counseling Service (RCS). It would provide that the Secretary may alter that structure only after providing this committee, and its counterpart in the House, with a report regarding any proposed changes. The Department would have to wait at least 60 days after submitting the report before implementing the proposed changes. Finally, the bill would require that each year, the President's Budget must specifically state the amount requested for readjustment counseling, including the amount requested to fund the Advisory Committee on Veteran Readjustment Counseling.

Mr. Chairman, we believe the Readjustment Counseling Service is working well under the existing structure, and we have no plans to change it. If at some point in time we determine that the organization does need change, I can assure you that we would inform the Congress of our plans, and we would work with the Congress, Veterans Service Organizations, and other interested parties to make certain those plans are workable. For that reason, we don't believe it is necessary to enact a provision such as section 2 which would dictate the existence of a specific structure for the Readjustment Counseling Service, and mandate a specific time frame for reporting changes to the Congress. I would also point out that each year in the President's budget, we identify the amount requested for the Readjustment Counseling Service, and it is unnecessary to provide for that in this bill.

Director of the Readjustment Counseling Service

Section 3 of the bill would elevate the position of the Director of the Readjustment Counseling Service to that of an Assistant Chief Medical Director (ACMD). It would also establish the qualifications for that position. For all practical purposes, the current Director serves much like an ACMD, and we do not oppose that change.

Eligibility for Readjustment Counseling

Section 4 would make all veterans eligible for readjustment counseling services. The law currently authorizes us to provide those services only to Vietnam era veterans, and veterans who served in the Persian Gulf, Lebanon, Panama, and Grenada. The Department supports extending these services to wartime veterans who served in areas of conflict, particularly those who served in World War II and Korea, but we don't believe it would be appropriate to expand the program to all veterans.

Since their inception in 1979, the Vet Centers have primarily addressed the needs of veterans who served in war zones. Although all Vietnam Era veterans are eligible for services, most demand has been from those who actually served in Vietnam. Over the years eligibility has been extended to others who served in the Persian Gulf, Panama, Grenada, and Lebanon. The focus of the program on war zone veterans recognizes the special readjustment needs those individuals have, including post-traumatic stress disorder resulting from combat area experiences. That focus has also served to distinguish Vet Centers, and make them unique from other mental health clinics which seek to meet the needs of a much wider population.

To extend eligibility for services to all veterans would not only require very significant infusions of resources, but could fundamentally change the nature of Vet Centers and the counseling program. In our view, veterans who served in combat are deserving of the special attention that the Readjustment Counseling Service now provides, and we should not detract from that program by trying to meet the much broader readjustment needs of the entire veteran population.

Bereavement Counseling in Vet Centers

Section 4 would also authorize us to provide bereavement counseling in Vet Centers to the families of all veterans who died while on active duty, or who die as a

result of a service connected disability. The Department supports a limited bereavement counseling role.

Over the years, Gold Star parents, spouses, and children of Vietnam veterans have occasionally come to Vet Centers seeking assistance in resolving psychological issues arising from the loss of a family member killed in action in Vietnam. We believe it would be reasonable to specifically authorize the Department to provide counseling services for next-of-kin of veterans who died in a war zone or as a result of injuries or illness incurred in a war zone. That would be manageable in terms of resources, and would not change the nature of Vet Centers as entities serving the specific needs of those who served in a war area. However, we cannot support as broad an authority as provided in this bill.

Confidentiality of Vet Center Records

Section 5 would statutorily make Vet Center records confidential, and would permit disclosure only with the consent of the veteran, except in very limited circumstances. The bill would authorize disclosure without consent only to medical personnel in a medical emergency, to other VA personnel to avoid imminent danger to the veteran or another, or if a court orders disclosure for good cause shown.

Since the inception of the Vet Centers in 1979, the Department has generally followed a policy of confidentiality for Vet Center records. We continue to support the principle of confidentiality for these records.

However, we are concerned that without further analysis and specifications, the language of Section 5 might function in some situations in a way that Congress would not intend. Specifically, we would like to work with committee staff to draft language which would be more appropriate in that it might take account of certain contingencies such as litigation, General Counsel's responsibilities for advising agency personnel, reporting of suspected child abuse, and other similar matters. Converting that to statutory language requires taking account of various exceptional situations.

Advisory Committee on the Readjustment of Veterans

Section 6 would statutorily establish an Advisory Committee on Readjustment Counseling. In essence, it would provide a statutory basis for the current Advisory Committee on the Readjustment of Vietnam and Other War Veterans. The section would provide that members of the current committee would become members of the new committee. The bill contains many detailed provisions pertaining to the membership on the committee, its operation, and its functions.

As you know, the President has ordered a detailed review of all existing advisory committees. Until that effort is complete, we cannot support provisions which would establish additional advisory committees.

Vietnam Veteran Resource Centers

Section 7 would require that we prepare and submit to this committee, and its counterpart in the House, a plan for converting all Vet Centers into Vietnam Veteran Resource Centers. The plan must contain a timetable for this effort.

Several years ago, at the direction of Congress, VA undertook a pilot program in several Vet Centers to provide additional services to those eligible for readjustment counseling. These resource centers provide benefits counseling, employment counseling, training and placement, intake and referral services with respect to those needing help for substance abuse disabilities, and general coordination of benefits. VA has continued funding the original ten resource center sites which participated in the pilot program between 1986 and 1988.

Although there may be merit in expanding the resource center program to all Vet Centers, to do so would require the use of funds now devoted to other VA programs. At this time, we are not prepared to argue that such expansion would have a higher priority than many other valuable programs competing for available funds.

Vet Center Outpatient Care Pilot Program

Section 8 would direct that we carry out a new two-year pilot program to provide veterans with outpatient medical services at Vet Centers. In our view, Mr. Chairman, this new authority is unnecessary and unwise.

The bill directs that we identify 12 to 15 Vet Centers in diverse locations to serve as sites for furnishing veterans with varying degrees of outpatient care. Those eligible for services would be service-connected veterans rated at least 30-percent disabled or who seek care for their service-connected disability, very low income nonservice-connected veterans, and a few others including former POWs and World War I veterans. At five sites, we would have to provide a minimum of 20 hours per week of "basic ambulatory services and health care screening." At five other sites, we would provide at least 40 hours per week of "full-range ambulatory services." Finally, a minimum of two sites would have to provide at least 120 hours per week

of physician services." The bill also calls for a report to Congress at the conclusion of the pilot program.

In our view, providing basic health care services in Vet Centers would fundamentally change the unique nature of these facilities. Much of the success these entities have experienced over the last 14 years can be attributed to the fact that they are not outpatient clinics providing routine medical services. Veterans can go to Vet Centers without feeling that they are patients seeking medical care. Rather, the centers are places where veterans who have suffered the psychological ravages of war can find assistance from counselors who often have had experiences similar to those of the veteran. A large proportion of counselors in Vet Centers are themselves Vietnam veterans. We believe that to introduce basic outpatient health care services into the mix of services now provided by Vet Centers could compromise the continued success of those facilities.

Mr. Chairman, there is absolutely no doubt that providing care in outpatient clinics is the way that medicine is practiced today. As you know, the Department operates many independent outpatient clinics. We know that such clinics work, and do not believe this pilot program would furnish us with particularly valuable information.

I would also point out that we already have the authority which would permit us to furnish outpatient services through Vet Centers. Indeed, in six places Vet Centers are located side-by-side with clinics providing outpatient care. However, those are unique situations that have occurred in Hawaii and the Caribbean to overcome unusual access to care problems. The facilities are carefully tailored to make certain that the Vet Center maintains its nature as a counseling center, not a medical clinic.

Finally, I would point out that implementation of this proposal would require diversion of funds from existing VA programs. It would likely require shifting current VA personnel from existing outpatient settings into Vet Centers. In some instances, Vet Centers would likely have to be relocated to obtain sufficient space to provide required services. We do not believe this pilot program would be an effective use of these resources.

DRAFT BILL—MENTAL ILLNESS RESEARCH, EDUCATION, AND CLINICAL CARE CENTERS

Mr. Chairman, your draft bill would call for us to establish and operate up to five VA health care facilities as centers for mental illness research, education, and clinical care, often referred to as MIRECC's. These entities would be patterned somewhat after VA's very successful Geriatric Research, Education and Clinical Centers, known as GRECC's. Proposals similar to this bill have been before the Senate for at least the past five years, and the Senate, but not the House, has repeatedly passed legislation authorizing MIRECC's.

As the Department has stated in the past, it is not clear that legislation is needed for us to establish MIRECC's. Decisions on whether to establish any of these facilities have been, and continue to be, determined by resource constraints and competing mental health needs. Your bill recognizes the resource issue by providing that we could create these MIRECC's only if appropriations are specifically provided for that purpose. However, if Congress were to provide additional funds for mental illness research, education, and clinical care, we believe that we should be allowed to determine how to use the funds to maximize services and care for the most veterans.

OVERSIGHT ISSUES

Mr. Chairman, I will next turn to the oversight issues before the Committee today.

Overview of VA Mental Health Programs

The Department of Veterans Affairs (VA) provides a full continuum of care for veterans suffering from mental disorders, from the most intensive inpatient treatment units to innovative outpatient programs designed to help chronically mentally ill patients remain in their communities. Most of the mental disorders VA treats are chronic, characterized by remissions and exacerbations rather than permanent cures. Many veterans suffer from more than one mental disorder concurrently. We frequently find an association of an alcohol or other substance abuse disorder with a major psychiatric disorder such as schizophrenia or Post-Traumatic Stress Disorder (PTSD). In addition, many veterans suffering from mental disorders also have medical problems such as cardiac or pulmonary disease. To meet this challenge, VA must provide comprehensive care to address the range of mental and medical disorders presented by our patients in the most effective and cost-efficient way.

Although many psychiatric inpatients require only short hospital stays, a significant portion with severe chronic mental illness require substantially longer stays in the hospital. We are treating increasing numbers of demented elderly veterans, which dramatically increases the per patient cost of VA psychiatric care. Even with medication, therapy takes time and there are no quick fixes. Serious chronic mental illnesses such as schizophrenia are rarely cured, and relapses usually occur. New studies show that two-thirds of alcohol abuse patients and 80 percent of schizophrenia and PTSD patients are still using VA health services six years following their initial treatment.

This year, VA will provide approximately 195,000 episodes of inpatient psychiatric care, with approximately 14,700 psychiatric inpatients in VA facilities at any given time. Approximately 44,000 veterans with serious psychiatric and/or substance abuse problems receive treatment in VA or VA-supported nursing homes, with approximately 17,000 receiving such treatment in VA Domiciliaries.

VA also provides outpatient mental health treatment to over 480,000 individual patients each year. Outpatient care has increased steadily and substantially since the mid-1980s—reflecting a general trend fueled by both cost and treatment concerns toward more outpatient and community-based care rather than inpatient care for psychiatric patients. VA also provides a growing but still relatively small number of veterans with various forms of community-based residential care for psychiatric disorders. VA's substance abuse halfway houses and Homeless Chronically Mentally Ill veterans program residential care component are the two biggest programs of this type, providing about 5,700 and 3,000 veterans, respectively, with community-based residential care. Taken together these efforts provide psychiatric services, including substance abuse treatment, to about half a million veterans each year.

The shift to non-institutional care reflects the fact that community-based or outpatient psychiatric care is often more therapeutically appropriate than inpatient care and can be more cost-effective. At the same time, replacing inpatient psychiatric care with community-based treatment cannot work properly without proper staffing and effective linkages with social services and appropriate housing—and providing the necessary staffing and linkages can reduce or eliminate any cost savings. Moreover, aggressive inpatient rehabilitation is more expensive than simple custodial care. As VA improves inpatient rehabilitation and continues its shift to outpatient and community-based care, the desire for cost savings must be balanced against the need to provide adequate resources to ensure maximum therapeutic benefits. Also, this trend to non-institutional care is constrained by current eligibility rules. Veterans with nonservice-connected (NSC) mental disorders who also have low incomes are eligible for VA inpatient treatment. However, many are eligible for outpatient treatment only if it is to avoid hospitalization, or in follow-up to institutional care, and if there is excess capacity. Accordingly, many NSC veterans either go without any treatment or only receive inpatient treatment once their condition degenerates far enough. Clearly, providing outpatient care to prevent the initial exacerbation of their problems or to maintain the benefits from inpatient treatment is a more clinically appropriate (and probably less costly) alternative. But this option is restricted by the combination of the fundamental scarcity of such outpatient services and current eligibility rules.

In 1991, the Congress was generous in providing \$6 million to enhance patient care in our long-term psychiatric facilities. Twenty-nine VA medical centers which have played a special role in treatment of long-term mental illness have benefited from this funding. Fourteen received funds for specialized programs directed specifically toward the chronically mentally ill, and the others have participated in ongoing educational and consultation activities. We are in the process of evaluating these programs and activities and will share the results when they are available. Following the June 29, House Veterans' Affairs Committee hearing on Treatment of Chronically Mentally Ill Veterans, VHA decided to devote its August Planning Review Committee meeting to the programmatic needs of chronically mentally ill veterans. VHA also intends to focus additional research resources on this special population.

Homeless Assistance Programs

It has been estimated that a third of the adult homeless population in this country are veterans and that on any given day as many as 250,000 veterans are living on the streets or in shelters. Similar to the general population of homeless adult males, about 40 percent of homeless veterans suffer from mental illness and (with considerable overlap) slightly more than half suffer from alcohol or other drug abuse problems.

VA offers an array of special programs and initiatives specifically designed to help homeless veterans live as self-sufficiently and independently as possible. VA's programs provide treatment, referrals, ongoing case management, residential treatment, transitional housing and other housing assistance to homeless veterans.

During this current year VA is expanding these special programs with special funding provided in our FY 1993 Appropriation.

In addition to medical center and clinic-based programs, VA offers services to homeless veterans at its 201 Vet Centers, which because of their strategic community-based locations can effectively provide outreach and counseling.

Despite the special priority that VA's programs receive, VA does not have the resources to assist every homeless veteran. Ending homelessness among veterans, or all homelessness, will take a combined effort by Federal, State, and local government, the private sector, and voluntary efforts. Toward this end, VA has developed numerous partnerships at the local level with public and private agencies and non-profit organizations, including veterans service organizations.

Substance Abuse Treatment Programs

At the end of FY 1992, VA operated substance abuse treatment programs at 159 of its medical centers and outpatient clinics. During FY 1992 inpatient substance abuse rehabilitation programs treated over 60,000 veterans with a substance abuse diagnosis. In addition to those veterans seen on specialized units, another 28,000 patients with substance abuse disorders received care on VA general psychiatry units, and 53,400 on VA medical and surgical units. VA outpatient substance abuse programs provided almost 1.9 million visits to over 108,000 veterans in 1992.

VA also contracts with non-VA community half-way houses for rehabilitation services for veterans with substance abuse disorders. During FY 1992 the \$8.6 million allocated to this program supported nearly 6,000 veterans in an estimated 300 community half-way houses for 60 to 90 days of care.

VA's substance abuse treatment programs were significantly expanded in 1990 with an additional \$60 million provided in our appropriation. In FYs 1991, 1992 and 1993 additional increments of \$15 million were allocated to substance abuse expansion. These resources have been utilized not only to continue the enhancement of treatment activities already mentioned, but also to support programs addressing PTSD and substance abuse, substance abuse among homeless veterans, substance abuse and family violence, and substance abuse among the elderly.

PTSD Services

VA has created a full range of programs for care of patients suffering from PTSD, and has led the nation and the world in developing the understanding and treatment of this disorder. Several types of specialized programs are tailored for the treatment of veterans suffering from Post-Traumatic Stress Disorder. These programs are designed to provide a continuum of care ranging from intense long term inpatient treatment to specialized outpatient care in VA medical centers, clinics, and Vet Centers. VA is expanding these programs with special funding from our FY 1993 Appropriation and has requested additional expansion resources from Congress for FY 1994.

VA's National Center for PTSD carries out a broad range of multidisciplinary activities in research, education and training. The National Center, established in 1989, is a consortium that currently is comprised of six sites. The Executive Division, located at VAM&ROC White River Junction, carries out strategic planning and directs the overall operations of the National Center. The Behavioral Sciences Division at the Boston VAMC develops scientifically validated instruments to measure PTSD. Both psychological and psychophysiological assessments are investigated. The Clinical Neurosciences division at VAMC West Haven is one of the few sites in the world investigating the effects of severe stress on brain function and developing new biological approaches for the diagnosis and treatment of PTSD. The Clinical Laboratory and Education Division, at the Menlo Park VAMC, built around a 106-bed inpatient PTSD and Dual Diagnosis program, including a women's unit, serves as a major site for inpatient research protocols, sleep studies, and cross-cultural investigations. A Women's Health Sciences Division, located at VAMC Boston has been added to the consortium in 1993. It will focus on research and education on the psychological impact of military service on women veterans. The Pacific Center for PTSD, created in 1992, will also become a Division of the National Center in 1993. Although not funded by the National Center, the Northeast Program Evaluation Center at VAMC West Haven, provides ongoing PTSD evaluation of all VAMC and VA Outpatient Clinic based PTSD programs.

Since 1984, VA's PTSD programs and VA's ability to provide PTSD care has been monitored by the Chief Medical Director's Special Committee for PTSD. The Special Committee is made up of a multidisciplinary group of VA clinician experts on PTSD.

The Special Committee submitted seven annual reports to VHA and Congress and is preparing an eighth Report for 1993. Many of VA's innovations in PTSD care (e.g. PTSD Clinical Teams) were derived from the recommendations of the Special Committee.

Mental Health Research

A strong program of mental health research is essential to maintaining and enhancing the quality of care provided by VA to veterans with mental disorders. VA has a laudable record of mental health research encompassing many disorders common to the general population such as schizophrenia as well as conditions relating directly to military experience such as PTSD. Clinical scientists in VA have made important contributions in investigating the role which dopamine plays in schizophrenia. There are three centers of excellence for schizophrenia research and comprehensive programs of research in alcoholism and substance abuse as well as PTSD. All 128 hospitals conducting research have projects in mental health research.

Most VA research support is awarded to physician-investigators by VA's Medical Research Service which provides funding for investigator-initiated studies based on the quality of the proposed research as established by a peer-review process. In FY 1992 there were about 1,350 VA scientists investigating aspects of mental health disorders ranging from basic science studies of neurotransmitters and neurochemical changes underlying schizophrenia, affective disorders and cognitive deficits, to comparative treatment studies in various forms of mental illness and dysfunction to outcome and cost impact studies. They represent 19% of all VA investigators with research funding. The VA provided about \$47.6 million for this research and an additional \$54.6 million came from extra-VA sources such as NIH. VA mental health investigators have been highly competitive in obtaining such funding. Part of VA's research program is in Health Services Research and Development which studies factors related to the costs and outcomes of health care programs in the VA. The goal of this research is improvement in the quality, efficiency, and cost-effectiveness of health care delivery.

Mr. Chairman, in summary, VA's special substance abuse, PTSD, and homeless assistance programs (which treat homeless veterans with mental disorders or substance abuse problems) have success rates that compare favorably to non-VA treatment programs that work with similar (although usually less disadvantaged) populations. This is also true of VA's treatment of psychiatric patients. Concerns have been raised about the treatment programs for veterans suffering with chronic mental illnesses. VHA is reviewing its programs for treating this special patient population including the need to devote additional research resources. We will be pleased to keep the Committee informed of our progress.

PREPARED STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee, The American Legion appreciates the opportunity to address Department of Veterans Affairs mental health programs and other legislative matters.

At the outset, Mr. Chairman, we wish to acknowledge our appreciation for your leadership in calling this hearing and for the continuing efforts this Committee makes in seeking to improve the operational efficiency and effectiveness of VA's various health care programs. We truly believe VA is a national health care asset and will play a major role in the nation's future health care system. A lot of hard work is still before us in shaping and carrying out VA's role in national health care reform. We had hoped to be further along in the process by this time. However, we are enthusiastic about the opportunity VA will have within the health care community to demonstrate its ability to be an effective provider of quality health care on a national level.

Mr. Chairman, VA's Mental Health and Behavioral Sciences Service manages a wide variety of inpatient, outpatient and community-based programs for acute and chronic psychiatric conditions. In recent years, VA has been provided support and funding in an attempt to meet the needs of certain segments of the veteran population suffering from highly visible psychiatric conditions, such as post-traumatic stress disorder, substance abuse problems and homelessness. Over the past several years, when given adequate resources, VA has improved services to veterans in these specialties. We sincerely hope that future progress will build on the recent performance of these programs and that the Congress will continue to support these worthwhile activities.

There is another segment of the veteran population who suffers from other psychiatric disorders, including schizophrenia, whose care and treatment has not received such a high profile. Services to this group of veterans must be improved.

A major obstacle in the care and treatment of acute and chronic psychiatric patients is the current eligibility criteria. Unless a veteran is being treated for a service-connected psychiatric condition, VA can only provide outpatient treatment to obviate the need for hospitalization. There is a definite lack of continuity of outpatient care modules for nonservice-connected psychiatric patients. Throughout VA today, there is a need for greater community involvement in the care and treatment of acute and chronic psychiatric patients. However, the biggest and most optimal change for these patients would be achieved through the immediate development of eligibility standards which promote effective treatment at the most appropriate and cost-effective level of care.

Mr. Chairman, if VA will become a free-standing competitor within national health care reform, it must improve its ability to adequately treat all psychiatric conditions, in both institutional and community based settings. Currently, state hospital systems are unable to properly treat psychiatric patients due to decreasing resources and difficult-to-treat patients keep landing on VA's doorstep. A certain portion of these veterans will never be able to return to the community and will always be dependent on VA. A structured rehabilitation program, focusing on the quality and quantity of care, should be the treatment goal for this difficult-to-treat group of patients. The earlier the intervention in the treatment of certain mental illnesses, the better the chance for a successful re-entry to the community. In our view, VA must receive and devote adequate resources to effectively operate its mental health programs.

The direction in which VA needs to move with regard to establishing effective mental health programs to a large degree depends on sufficient funding and, as mentioned, changes in eligibility criteria. The American Legion witnessed the development and implementation of a biased funding formula with regard to VA mental health programs in the middle 1980s. The introduction of Diagnostic Related Groups (DRGs) negatively impacted the ability of VA to properly treat certain chronic psychiatric conditions. Many inpatient VA mental health programs were down-sized due to the impact of DRGs, without developing comparable community based program alternatives, while the outpatient programs were unable to meet the demand for care due to many factors. Today, Mr. Chairman, we are reviewing what impact VA's newest resource distribution methodology, the proposed Resource Planning and Management Process (RPM), will have on the ability of the Mental Health and Behavioral Sciences Service to properly manage its various programs. RPM is scheduled to begin on October 1, 1993.

VA projections about workloads in FY 1993 and FY 1994, show a trend for increasing psychiatry workloads. From FY 1991 to FY 1992, psychiatry treated 4,782 more inpatients, and projected workloads from FY 1991 to FY 1994 suggest a 10 percent increase for psychiatry (+19,240 patients). In FY 1992, psychiatry had 19.4 percent of VA's inpatient workload and 33 percent of the Average Daily Census (14,162 ADC). The FY 1994 projections suggest that psychiatry will have 21 percent of the inpatient workload and 35 percent of the ADC (15,120). In fact, forty percent of veterans treated by VA have psychiatric disorders. The projected increase in FTEE for psychiatry from FY 1992 to FY 1994 is 293 FTEE (+1.1%).

Mr. Chairman, The American Legion welcomes your support in assuring that VA mental health programs receive the funding necessary to deliver the proper care and treatment to a diversified veteran population. It is time to stop the revolving door approach, amend the eligibility criteria, and develop more community-based outpatient treatment alternatives, along with expanded rehabilitation programs and temporary community housing. Additional resources are needed to augment current staffing and to develop a full range of psychiatric treatment programs in order to achieve these objectives. In our view, VA needs to request these funds and target them to various mental health programs.

Mr. Chairman, we will now turn our attention to S. 1226, the "Readjustment Counseling Service Amendments of 1993." The bill would amend title 38, United States Code, to provide for the organization and administration of the Readjustment Counseling Service, to improve eligibility for readjustment counseling and related counseling, and for other purposes.

Section 2 of the bill would make the Readjustment Counseling Service (RCS) a statutory organization within the Veterans Health Administration, freezing its administrative structure as of January 1993 and establishing a line item in the budget for RCS. The measure would provide VA with the latitude to make changes to the structure of RCS, but only after appropriate Congressional review. The bill spells out a 60-day waiting period between announcement of any changes and the actual

implementation during which time the Congress may make their views known to the Secretary.

The American Legion supports this proposal. The Readjustment Counseling Service administers a program with 850 employees, 201 Vet Centers, seven regional offices, and a budget of upward of \$56 million. The unique readjustment counseling services and mental health programs that RCS manages are central to the mission of VA and vital to the health care of veterans. This section will dissuade any attempts to compromise RCS's independence by making RCS a statutory body, establishing obstacles for VA to clear before making substantive changes in the program, and providing for a protected budget to discourage shifting of funds to other programs.

Section 3 of the bill would amend section 7306(b) of title 38, USC, to raise the Director of RCS to the Assistant Chief Medical Director (ACMD) level and establish new qualifications for the position.

This proposal is consistent with section 2 of the bill, which calls for RCS to be codified as an independent organization within the Veterans Health Administration. The section also clarifies the academic and experience requirements for the position. The American Legion supports this proposal.

Section 4 of the measure proposes to amend subsection (c) of section 1712A of title 38, USC, to expand entitlement for readjustment counseling to all veterans meeting the criteria for VA services. Also, the measure would amend section 1701(6)(B)(ii) of title 38, USC, to expand eligibility for grief counseling to the surviving parents, spouse, and children of any member of the Armed Forces who dies while serving on active duty or from a condition incurred in or aggravated by such service.

Mr. Chairman, The American Legion commends Senator Akaka for having the vision and the courage to introduce legislation which would move VA away from traditional thinking on the structure and make-up of the Vet Center program. The Readjustment Counseling Service has been a dynamic force in addressing the most pressing issues facing the veteran population it serves. While the primary goal of the Vet Center program is to provide psychological counseling to assist wartime veterans' readjustment to civilian life, it has been active in other areas. Vet Centers have also assumed additional responsibilities in the areas of homelessness, disaster assistance, sexual trauma, alcohol and substance abuse, suicide prevention, the physically disabled and minority veterans. Where Vet Center counselors have been unable to directly assist veterans, they have been helpful in identifying and providing access to appropriate services offered elsewhere within VA or the community at large.

The American Legion believes the RCS can continue to provide effective counseling and other services to veterans. With qualification, we support the provision which calls for expanding RCS eligibility to all veterans. In our view, psychological counseling services, along with the full range of Vet Center services, should continue to be an entitlement for wartime veterans, as defined by the Congress. We must ensure that the resources and personnel of RCS remain a priority for wartime veterans' readjustment needs. We support the notion that all veterans should be eligible to access informational assistance and referral services offered by Vet Centers. The Vet Centers currently serve all veterans who seek basic benefits information. Section 4 of the bill would simply formalize existing practice. We caution, however, that a change in eligibility and a resultant increase in workload may require some new staff and resources.

The American Legion supports the provision calling for grief counseling to be made available to immediate survivors, including parents, of service members killed-in-action or in the line-of-duty, or as a result of service-connected disabilities. These services should be focused on individual and/or group bereavement counseling and be made available as required.

Section 5 of the bill proposes to codify existing policies regarding confidentiality of patient records in the Readjustment Counseling Service. Under section 5, a veteran's record could be provided to non-RCS personnel only if the veteran consents, if there is a medical emergency, if there is imminent danger to the veteran or others, or if a competent court orders the release of the record. The American Legion strongly supports this proposal.

Section 6 of the measure proposes to amend Subchapter II of chapter 17 of title 38, USC, to establish the current Advisory Committee on the Readjustment of Vietnam and Other War Veterans as a permanent committee and to be renamed, the Advisory Committee on Veterans Readjustment. It also addresses the composition of the Committee, which is to be comprised of at least two-thirds combat veterans.

Mr. Chairman, this committee is the chief advisory body to the Secretary on readjustment issues. Because the committee is comprised of non-VA members, it represents a point-of-view independent from the Department. Due to the unique nature of the committee's principle advisory role, we believe it is important to permanently

authorize this Committee's advisory role by statute. In relation to the proposed renaming of the Committee, The American Legion accepts the logic of the proposal. The renaming of the Committee would follow the expanded mission of the Readjustment Counseling Service. The proposal that the Committee be comprised of at least two-thirds combat veterans would not differ from the historic composition of the Committee since its inception. The American Legion does not object to this proposal.

Section 7 of S. 1226 would require that VA submit to the Committees on Veterans' Affairs a plan, with an implementation schedule, for the expansion of the Vietnam Veteran Resource Center (VVRC) pilot program at or through all VA readjustment counseling centers. The proposal provides that the plan be drafted with the flexibility to implement the program on an appropriate scale at each vet center and shall not be submitted later than 4 months after the date of implementation of this Act.

Mr. Chairman, Public Law 99-166 mandated VA to conduct the Vietnam Veteran Resource Centers (VVRC) pilot program expanding the range of services at ten existing Readjustment Counseling Service Vet Centers. In addition to existing outreach and psychological counseling for post-war adjustment, the pilot VVRCs were required to provide additional services in the following areas: (1) veterans' benefits counseling and assistance; (2) employment counseling, training and placement; (3) intake, referral, and follow-up services for alcohol and drug abuse related problems; and (4) assistance in coordinating benefits and services. The VVRC concept was tested between December 1986 and August 1988. VA's report to Congress at the conclusion of the program indicated that the VVRC concept enjoyed considerable success. The original VVRC program was repealed by section 4(b)(6) of Public Law 102-83. However, even after authorization for the program had expired, VA chose to continue VVRC activities at those sites where they had been established. The VVRC concept was to have benefits counselors, DVOPs, and LVERs provide assistance to veterans in addition to the more traditional readjustment counseling.

In relation to section 7 of the bill, The American Legion supports the continuation of the original ten VVRCs. In all cases, the augmented staff positions and associated dollars for VHA service functions were generated entirely from internal redistribution of existing RCS resources. Each VVRC was augmented by at least two FTEE; one primarily devoted to employment services and the other to alcohol/drug abuse activities. Extensive liaison and reciprocal referral activities with local VA regional office staff were developed for addressing the veterans' benefits needs. Additional liaison activities provided by the Department of Veterans Benefits included the provision of DVB program materials to VVRC staff, in-service training of VVRC staff on DVB programs and services, periodic site visits by DVB staff, and, on an as-needed basis, part-time direct service by DVB personnel at VVRCs.

With regard to section 7, the Legion supports the notion that VA study the feasibility of expanding the VVRC program to additional Vet Centers. Of course, further expansion is a resource dependent proposal.

Section 8 of the measure calls for VA to establish a 2-year pilot program to test the practicality of offering limited health care services through Vet Centers. It requires VA to test three different health care models at 12 to 15 Vet Centers located in various geographic settings, including rural and urban areas, and serving veterans from a variety of economic, social, and ethnic backgrounds.

Mr. Chairman, VA now has the authority to provide limited health care services through Vet Centers. Currently, six vet center sites in Hawaii and the Caribbean offer such services. The American Legion believes that this proposal has merit in reaching new veteran beneficiaries residing in rural areas of the United States and in urban areas, particularly homeless veterans. Also, in the event that health care reform takes place, this concept could be a valuable marketing medium.

We recently testified before the House Veterans Affairs Subcommittee on Hospitals and Health Care that VA lacks a comprehensive rural health care policy. In developing such a policy, it would be highly appropriate for VA to determine the merits of this proposal. The scope of services and workload anticipated in carrying out this program would certainly be lower than in traditional outpatient clinic sites. Additionally, VA would have to be very careful in selecting sites for the pilot program as not all Vet Centers have adequate space for such a project. The Legion supports the attempt to determine whether side-by-side vet center and limited primary care services would significantly improve veterans' access to outpatient care. If enacted, responsibility for carrying out this proposal should rest with VHA and not involve the services or staff of the Readjustment Counseling Service.

A draft bill under consideration today would amend title 38, USC, to require the establishment in VA of not more than five Mental Illness Research, Education, and Clinical Centers (MIRECCs), and for other purposes. The purpose of this proposal is to improve the provision of health care services to eligible veterans suffering from mental illness, especially mental illness related to service-connected conditions,

through research, the education and training of health care personnel, and the development of improved models for furnishing clinical services.

Mr. Chairman, the proposal to establish and fund MIRECCs has been supported by The American Legion on several recent occasions. The Legion recently testified before the House Veterans Affairs Subcommittee on Hospitals and Health Care that there are serious deficiencies with regard to the care and treatment of chronic psychiatric patients in VA. Additional resources, along with an increased focus on mental health care outcome research to understand what treatment works best for particular conditions is vitally needed.

In relation to the draft legislation, the Legion supports the creation and funding of MIRECCs, tied to certain organizational system changes. We feel that large tertiary facilities, who most likely would receive approval to establish the MIRECCs, could best carry out the mission of the program by linking-up with large long-term non-affiliated psychiatric facilities, and include a focus on long-term psychiatric care in their research functions. In sum, a MIRECC could potentially include more than one VA facility.

Mr. Chairman, that concludes our statement.

PREPARED STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL
LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN
VETERANS

Mr. Chairman and Members of the Committee, on behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I want you to know how deeply appreciative we are for the opportunity to share our views on S. 1226, the "Readjustment Counseling Service Amendments of 1993," introduced by the distinguished member from Hawaii, Senator Akaka; and, draft legislation, proposed by yourself, Mr. Chairman, to create Mental Illness, Research, Education and Clinical Centers (MIRECCs); and VA's programs for the treatment, and rehabilitation of the chronic mentally ill, especially in the areas of outreach, research and clinical care.

S. 1226

I would state, initially, Mr. Chairman, the DAV's general support for this measure and its perceived intent of strengthening and expanding the scope and services provided by the Readjustment Counseling Service (RCS) and its nationwide system of 201 Vet Centers. Also, we would like to take this opportunity to express the DAV's appreciation and gratitude to Senator Akaka for his recognition of the importance of RCS to Vietnam and other veterans and the proactive manner taken to address the issue.

To quote Senator Akaka, "... the Vet Center Program is well worth preserving. It is a national resource that has proven its worth many times over since its establishment 15 years ago."

Mr. Chairman, those few simple words very aptly describe a valuable program and national resource operated by the many dedicated and committed VA employees who make it function for the betterment of veterans and their families on a daily basis.

Mr. Chairman, the DAV has continually expressed its commitment and concern toward assisting Vietnam Era, as well as other veterans suffering psychological problems associated with their military service. It was the DAV that provided funds for the "Forgotten Warrior Project" study which led, in October 1979, to the DAV initiating its own Vietnam Veterans Outreach Program. The result of that study had a direct influence on not only our organization's establishment of a specific counseling program for Vietnam Era veterans but, we feel, on the decision of Congress to provide the necessary funds which authorized the VA to create "Operation Outreach" and subsequently establish a network of Vet Centers as we know them today.

It is our sincere belief, Mr. Chairman, that the need for RCS will be omnipresent for as long as there are hostile conflicts or the potential of conflicts that involve this nation's young men and women. The emergence of RCS as the program that effectively deals with readjustment issues and the VA employees who have been involved in the program since its inception, provide a solid foundation upon which RCS will be able to continually meet veterans', largely combat veterans, unique needs. No other such program exists to our knowledge.

Having made that statement, we are, nevertheless concerned that should the provisions of Section 2 of this measure become law, the continued existence of Vet Cen-

ters may very well be jeopardized to the extent the program may not be able to effectively function.

Mr. Chairman, standing virtually alone and without meaningful, substantive changes, the continuation of a program created to provide Vietnam veterans assistance in readjusting to civilian life will, undoubtedly, be called into question by opponents of the program.

Mr. Chairman, our single overriding concern is the potential persuasiveness of such an argument.

While it is not our intent to suggest Vet Centers be under the strict unilateral "control" of medical center directors, we do believe that to statutorily mandate a total segregation from the mainstream VA health care delivery system, however well intentioned, could prove to have the opposite effect of that contemplated by Section 2.

Section 3 proposes amendment to Section 7306(b), Title 38, USC, creating an Assistant Chief Medical Director (ACMD) of RCS and establishes new qualifications for that position to include to be considered for the ACMD a qualified psychiatrist, psychologist, Master in Social Work, or a Registered Nurse possessing a Master of Science degree in psychiatric nursing. Additionally, criteria would be included that would require at least three years of clinical experience and two years of administrative experience in RCS in order to be considered for the position.

Section 4 of the measure proposes to expand eligibility for readjustment counseling to any veteran, otherwise eligible for VA care, to be furnished such care through RCS. Also, eligibility would be created for bereavement counseling to the surviving parents, spouse and children of any veteran who died while serving on active duty or from a service-connected disability. The DAV is supportive of this provision.

Section 5, as we understand it, creates, statutorily, current policies regarding confidentiality of patient records. DAV has no objection to this proposal.

Section 6 proposes to alter the current Advisory Committee on the Readjustment of Vietnam and Other War Veterans to a statutorily mandated Committee, renamed the Advisory Committee on the Readjustment of Veterans. Also, the Committee would be charged with assembling and reviewing pertinent information relating to veterans readjustment issues and creates a timetable that the Committee would be required to submit reports to the Secretary who, in turn, would be mandated to transmit such reports to the Committees on Veterans Affairs. The DAV has no objection to this proposal.

Section 7 of the bill would require the VA to develop and submit to the Congress a plan for the expansion—or re-creation—of the Vietnam Veterans Resource Center (VVRC) program. The VVRC, conceived by Public Law 99-166, envisioned a limited number of existing Vet Centers to significantly and meaningfully expand the scope of services they were able to provide to disabled veterans. We believe the intent of the VVRC program is a good one and should, when and where resources permit, be pursued.

Finally, Mr. Chairman, Section 8 of the measure proposes a two year pilot program to determine the feasibility of offering health care services at Readjustment Counseling Centers. It is our sincere belief that the concept of providing certain health care services to eligible veterans at Vet Centers is long overdue. Unquestionably, such a program can only serve to have a positive effect on veterans and their health status.

Clearly, Vet Centers are well accepted by their user population, they are cost effective, basically "hassle free" and, importantly, exist in the community where veterans reside and therefore are easily accessible.

In addition to the fully defined psychological needs of veterans seeking services at Vet Centers, it would seem that their existing physical disabilities will require the seeking out of medical care at some point. As Vietnam veterans age, it will be inevitable that the presence of additional disability and disease will manifest and, we can envision Vet Centers, playing a significant role in the early detection and treatment of additional disabilities by means of having VA health care personnel physically located at Vet Centers.

Mr. Chairman, we would estimate no or relatively little additional costs would be incurred in such a venture. Medical staff from a nearby VA medical facility would be assigned to the Vet Centers as indicated by local need and within available resources. We envision physicians, nursing staff, physician assistants, dietitians, etc., all will have meaningful roles to play.

We are, therefore, totally supportive of such a concept being implemented, where appropriate, in Vet Centers.

DRAFT LEGISLATION

Mr. Chairman, the DAV is pleased to state our support for your proposed legislation that would create Mental Illness Research, Education and Clinical Centers (MIRECCs).

As we understand it, a new Section, 7319 would be added to Title 38, USC, establishing MIRECCs for the express purpose of improving the provision of health care services to eligible veterans suffering from mental illness, especially mental illness related to service related conditions, through research, education and training of health care personnel, and the development of improved models for furnishing clinical services.

Under your proposal, Mr. Chairman, the Under Secretary for Health would be required to:

- Designate not more than five VA health care facilities as MIRECCs;
- Designate at least one facility not later than January 1, 1994;
- Ensure that MIRECCs are located in various geographic regions of the country.

Additionally, MIRECCs could not be created at a health care facility unless that facility had developed:

- An affiliation with a medical school providing education and training in psychiatry;
- An arrangement with an affiliated school of psychology providing education and training in clinical or counseling psychology, or both;
- An arrangement under which nursing, social work or other allied health personnel receive training and education in mental health care through regular clinical rotation through the VA facility;
- A demonstrated ability to attract scientists who have documented achievement in research in the area of mental illness.

Also, the VA would be required to ensure that useful information garnered as a result of research, as well as training and clinical, activities of the MIRECCs is appropriately disseminated throughout the VA health care system through programs of continued medical and related education.

Finally, the measure would authorize to be appropriated for Fiscal Year 1994 the sum of \$3.125 million and for each of the Fiscal Years 1995, 1996 and 1997, \$3.25 million.

We request the Committee to give consideration to adding language dealing with a peer review process to be included in both the site selection process, as well as the various research proposals that will come from the MIRECCs. In our view, it is critically important that VA continue to engage in research that is of the highest possible caliber. A peer review process certainly helps to assure that is the case.

It is especially critical today, as our nation readies itself for comprehensive health care reform and the VA stands in the wings poised to embark on their own reform proposals, that we discuss what many have described as an area in which VA has particular strength and expertise—mental health treatment.

Mr. Chairman, it is our impression that veterans place a heavy reliance on the VA health care system to meet their mental health care needs. Data indicates over 50 percent of all veterans requiring psychiatric care receive such care from the VA. This is, indeed, a meaningful and telling figure.

Seemingly, certain VA programs—PTSD, substance abuse and initiatives for the care of the homeless—have fared well over the recent years where funding is concerned. This does not suggest, however, that all is well in those specific programs.

However, what we would suggest is that all other programs and clinical areas have not done well, budgetarily. In fact, a consistent erosion in funding has occurred.

What this translates to, Mr. Chairman, is that many veterans suffering mental illness have experienced increasing difficulties when attempting to have their treatment needs met. Rationing of care and in many instances denial of care are commonplace.

Complicating, and in fact contributing to this dilemma has been the VA's treatment model of caring for this category of veterans in an institutional setting. Recent developments and innovations are beginning to move VA more in the direction of outpatient care and other alternative programs. However, some 80 percent of VA's mental health dollars are used solely for inpatient care.

Mr. Chairman, the VA is in the unique and enviable position to be able to influence the future direction of mental health care not only to the veterans it is charged to serve, but also, we believe, to the nation as a whole.

VA has the means to do so by virtue of operating as our only real national health care system. Additionally, it treats a population that is older than the general popu-

lation with a higher percentage of patients afflicted with chronic mental health disease.

Because it is a national system, the potential for research activities is present. Finally, as a system, VA has a vast array of programs and services available for the psychiatrically impaired patient.

Mr. Chairman, it is our position that VA does a good job in providing mental health care, however, we believe the potential exists for them to do significantly more.

VA needs to develop a commitment and system wide focus with standards for the treatment of chronic mentally ill veterans via a continuum of services to include alternatives to inpatient hospital care. Many wonderful programs exist but in a largely uncoordinated manner.

I would also suggest, Mr. Chairman, that there is a significant potential for the successful treatment and rehabilitation of veterans with psychiatric disorders. To do so, however, will require a dedicated system of care that is well organized, managed and coordinated. Such a system must be able and willing to offer a full spectrum of comprehensive, nontraditional and alternative modes of care stressing reentry into the community and ultimately independent self-sustained living.

Mr. Chairman, this concludes our testimony and I would like to once again thank you for allowing us to offer our views regarding these important issues pertaining to VA health care.

PREPARED STATEMENT OF TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, on behalf of the Members of Paralyzed Veterans of America (PVA), I wish to thank you for inviting us today to present testimony concerning the Department of Veterans Affairs' (VA) mental health programs.

The VA health care system has, over the years, tailored certain services to the specific needs of veteran patients to a degree for which there is no comparable counterpart in the private medical sector. The VA Mental Health and Behavioral Sciences Service is typical of such a service. Other examples include Prosthetics and Rehabilitation, Spinal Cord Injury, Blind Rehabilitation, Geriatrics and Long Term Care.

The sheer volume of mental health workload and wide variety of programs exceed what reasonably could be absorbed by public and private providers should the VA system ever be discontinued, or its services diminished, in the course of national health care reform. It is in anticipation of the impact on the VA health care system from most scenarios for health care reform that characteristics of the VA Mental Health and Behavioral Science service take on special meaning.

For this reason it is imperative that in anticipation of enactment of national health care reform the unique VA role and function providing mental health services for veterans be clearly defined. The Congress should enact legislation providing entitlement for all Core Group veterans (consisting mainly of the service-connected and medically indigent veterans) to receive the full continuum of mental health services beyond the current inpatient care limitations. This entitlement reform should give both veterans and providers the benefit of a broader mix of treatment alternatives—ambulatory care, halfway house and other forms of non-institutional rehabilitative services—to provide more cost effective and efficient treatment modalities.

According to the National Institutes of Health, over fifty percent of all veterans in need of mental health services receive that care through the Department of Veterans Affairs (VA). In recent years approximately 40 percent of all the 3 million individual patients seen annually in the VA system are veterans with mental health disorders, and account for some 20 percent of all VA outpatient visits. Nationally, VA appears to provide about 36 percent of all veteran hospitalizations in psychiatry.

It is unlikely, under any national scenario of health care reform, that the basic medical benefit insurance package would provide anything approximating what the mentally ill veteran receives in the VA, in either volume or variety. Nor would most non-indigent veterans have the financial means to avail themselves of what psychiatric care is offered outside the VA system.

Aside from the psychoses, VA behavioral services also deal with multiple psychosocial disorders for which veterans as a group are at high risk, particularly homelessness, substance abuse and post-traumatic stress disorder (PTSD). These conditions often feed on each other, and providers must coordinate responses to best treat the underlying causes of the veteran's disorder.

Commendable progress has been made toward progressive increase in non-institutional workload for these programs and serve as an example of VA's full potential for other types of ambulatory care.

A short reference is made to the success of those psycho-social disorder programs and a concern that perhaps the pendulum of resource commitment needs to shift in a manner to achieve comparable prevalence of non-institutional venues for care of the chronically demented and other long-term psychiatric patients. The Homeless Chronically Mentally Ill (HCMI) program was begun in 1987 and since that time the VA has had contact with approximately 10,000 veterans per year. VA estimates that from one-third to one-half of the nation's homeless are veterans, that the number of homeless veterans could be as high as 250,000 and that two-thirds of that number are likely to be drug or alcohol addicted. VA also states that up to 45 percent of those enrolled in the HCMI have serious medical conditions. Veterans who need psychiatric and medical care are aided through VA clinics and community-provided rehabilitative services.

Even more spectacular has been the success of the PTSD program for which the Congress has also been heavily committed through specified incremental appropriations. The National Vietnam Veterans Readjustment Study claims that approximately 500,000 Vietnam-era veterans need treatment for this disorder, with unknown numbers from other wars.

The non-institutional options so successful in both of the above programs could be repeated for other types of mental illness. Unfortunately, because of the perversity of current entitlement rules, the majority of the Core Group veterans cannot be offered out-patient care. As a result they are either provided more expensive hospitalization or, more often, denied access to VA care altogether. This is but one glaring example of the need for entitlement reform.

There are already established limited modalities of outpatient care for mental illness—including ambulatory clinics, adult day care centers, and home care. However, the same imbalance exists, tilted toward institutional psychiatric care, as is present in general medicine and surgery programs—not only in the VA, but to a lesser degree across the nation's health care industry. Eighty cents of each dollar spent by the VA on mental illness goes to inpatient modalities of care. VA has made a start on this shift of venue, but is far short of what is required if it is to earn the opportunity for a place in tomorrow's competitive medical market. To meet acceptable standards of efficient and economic delivery of care, much more emphasis, including capital investment, needs to be placed on ambulatory programs for the chronically mentally ill veteran.

Although the total number of veterans is slowly declining, recent studies by VA staff indicate that the use of psychiatric services for veterans will increase. This is due to the fact that cohorts currently demonstrating high-use of psychiatric services are advancing into age groups with even higher utilization patterns. For example, Vietnam era veterans, who have demonstrated high use rates, will be using even more services as they age. It is in the aged that mental illness reaches the highest incidence. Whereas current projections indicate an overall decrease in the number of veterans with service needs for psychiatric inpatient care, the new projection methods indicate an increase in the requirement for psychiatric and nursing home beds concomitant with significant decreases for surgical and medical beds.

If priority listing were ever made of the various VA medical care services, long term care, in all of its aspects, deserves a primary mission identification.

The VA health care mission itself is changing and this must be recognized in the upcoming reform of the nation's health care system. Under certain reform scenarios attractive alternate sources of care for veterans may well reduce the VA acute care workload in medicine and surgery, but the demand for VA delivered care in both geriatric and mental illness will increase unabated.

Long term ambulatory and institutional chronic care, including especially that for psychiatric patients, will consequentially consume a greater proportion of the VA health care dollar in the future. A similar phenomenon will occur in the private health care industry although, intensity-wise, it is a decade behind that seen in the VA system.

Recognizing this should make policy makers aware that the demand for VA services in the future preclude it from being an effective competitor in an exclusively acute health care arena under national health care reform. Far more promising is the concept whereby VA places its principle focus on those specialized services at which it has historically excelled while providing the acute multispecialty clinical support commensurate with the specialized services' ancillary health care requirements.

RECOMMENDATIONS

- Enact veterans entitlement reform to mandate full continuity of care, with special emphasis on expanded out-patient venue, for all Core Group veterans.
- Provide incremental appropriations for expansion of VA plant facilities designed for ambulatory medical programs.
- Provide the staffing and resource enhancements for 30 existing long-term psychiatric care facilities.
- Provide 150 additional homes for therapeutic residences for veterans' industries programs and provide these programs as joint ventures with non-profit entities.
- VA should expand its nationally recognized expertise in geriatric medicine by supporting residencies and fellowships in geriatric psychiatry at no fewer than 10 VA medical centers.

PVA notes that much of the above described developments together with the pertinent recommendations for VA realignment were also contained in the Strategy 2000 report, "The VA Responsibility in Tomorrow's National Health Care System."

PVA is also pleased to comment on two bills designed to improve veterans health care services under consideration at this hearing.

MENTAL HEALTH RESEARCH, EDUCATION AND CLINICAL CENTERS (DRAFT BILL)

PVA fully supports the concept behind draft legislation proposed by Chairman Rockefeller that would authorize VA to establish no less than five Mental Illness Research, Education and Clinical Centers (MIRECCs) at designated VA Medical Centers. Due to the long-term nature of caring for the chronically mentally ill, caring for veterans with psychiatric conditions constitutes a considerable portion of the total patient days within the VA system. MIRECCs would utilize the same highly successful concept for mental health that has already given VA national reputation as a leader in geriatric clinical research and education through the establishment of the Geriatric Research and Education Clinical Centers (GRECCs). MIRECCs would target a prominent area of disability within the veteran population. They would also be a valuable addition to VA's superior research and training base.

PVA has two recommendations for improvements to the draft bill.

1. Section 7319 would give the Secretary of Veterans Affairs the authority to designate a MIRECC based on the recommendation of the Under Secretary for Health. This decision would be made pursuant to a series of provisions that would ensure geographic diversity of MIRECCs within the VA system and based on an analysis of the expertise in mental health available to the potential site from affiliated medical schools. Similar language was included regarding the field of geriatrics when the Congress originally authorized the GRECC program. PVA recommends however, that this criteria requirement be expanded to provide additional safeguards for quality in the MIRECC selection process.

Public Law 102-585, overwhelmingly approved by the House and Senate, required the Under Secretary for Health to establish a peer review panel that would review and rank GRECC proposals through a competitive process designed to identify their conceptual value and scientific merit. The provision would also prohibit the Secretary from designating a facility as a GRECC unless the peer review panel had determined under a specified process that the proposal met the highest standards of scientific and clinical merit. PVA believes that the draft bill should contain the same safeguards and traditional reliance on the merits of peer review process as contained in the GRECC language.

(2.) Both sections 7314 of Title 38 U.S.C. authorizing the GRECC program and the draft bill (section 7319 (F)(c)) contain language that would give research conducted at the respective centers priority in funding over other research funded by the medical and prosthetic research account. We understand that the language contained in the GRECC authorization was drafted to provide unique incentives to help promote the field of geriatric and aging research, a new and emerging area of medical inquiry. VA in the 1970's and early 1980's did provide certain monetary incentives for aging research projects. That policy ended in the middle 1980s. On a one-time basis as "seed money" VA provides special authority to fund up to five meritorious research projects at newly designated GRECCs. However, the Department has not found it necessary to reinstate an artificial system of prioritization to give aging research priority over any other area of meritorious scientific inquiry. For these reasons, PVA believes it is not necessary to include similar language in the draft bill relating to priorities for the already well-established field of mental illness research.

The bill would codify the administrative structure of Readjustment Counseling Service; expand eligibility to all veterans in need of readjustment counseling; plan for the expansion of a Vietnam Veteran Resource Center Pilot Program; establish a Veteran Center Health-Care Pilot Program; and, make other improvements to the Readjustment Counseling Service.

PVA fully supports the intent of this legislation. Historically, the Readjustment Counseling Program has maintained a separate administrative identity within the Veterans Health Administration (VHA). We believe that unique function should be maintained as long as the service requirements of the patient population justify the expenditure of resources to support the Vet Center approach to readjustment counseling.

PVA has consistently supported expanding eligibility for any veteran to receive counseling through the Vet Center system. Post-traumatic stress disorder and the psychological impact of wartime service is not unique to those who served during the Vietnam War. Vet Center services and expertise should be available to all veterans in need.

PVA also supports Section 8 of the legislation that would authorize VA to outstation clinical care teams at no more than 15 selected Vet Centers to provide basic ambulatory care and health-care screening. PVA has consistently supported the Vet Center Program for the services it has provided to Vietnam veterans and others in need of readjustment counseling. However, we have also cited the Vet Center approach for its future facility as an outpatient, community-based resource for all eligible veterans.

If VHA is to compete successfully within the context of a new national health care system it will have to reform its current Byzantine eligibility criteria to offer the full continuum of care, inpatient, outpatient, preventive and long term care services for all eligible veterans. In doing so it will have to realign its service delivery models, shifting away from expensive inpatient treatment to more appropriate and efficient outpatient care services. Such a shift will, in turn, require the system to expand its ambulatory capability at the medical center level as well as the community level to maximize patient access to these services.

Undeniably, as time passes, Vet Centers should experience a slackening of demand. As that happens, this valuable outpatient infrastructure, strategically located in 201 communities across the country, should not be lost to VA for other needed services. The legislation would establish a pilot program to provide basic ambulatory services at designated Vet Centers. PVA believes this to be a useful experiment. Both Vietnam veteran clients of the Vet Centers as well as other eligible veterans will benefit equally from these services. PVA, however, endorses this provision with the following reservations:

(1) Medical centers providing the Vet Center ambulatory care teams should be given additional funding to support this activity. One of the reasons VA has been unable to expand its outpatient base is that annual appropriations have fallen short of the necessary level to support increasing outpatient demand.

(2) The selection process that will identify which Vet Centers are to be chosen for the pilot program should ensure that these additional activities will not detract from the mission or the ability of the individual Vet Center to perform its original mandated function.

Mr. Chairman, thank you for this opportunity to express our views. I will be happy to answer any questions you may have.

PREPARED STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee, on behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to thank you for affording us this opportunity to testify with respect to the Department of Veterans Affairs' care of the chronically mentally ill. Given that a significant number of this nation's veterans are suffering from post-traumatic stress disorder (PTSD) as well as other mental disabilities incidental to their service in the United States Armed Forces, the VFW commends the chairman and members of this committee for holding this hearing today. Although the wounds of these brave men and women may not be physically apparent, the pain is nonetheless real and they certainly deserve all the help a grateful nation can provide.

Mr. Chairman, the Department of Veterans Affairs' psychiatric programs indeed serve a unique segment of the veterans population. These programs are often without peer within the private sector. Furthermore, VA psychiatric programs serve patients who would have little or no access to mental health services outside the VA system. In fact, mental health services make up an extremely sparse percentage in some of the most comprehensive private-insurance packages. Veterans who are less likely to have adequate coverage are even less likely to have adequate financial access to mental health benefits.

Although veterans are vulnerable to all the psychiatric disorders found in non-veterans, they are at particular "high risk" with respect to homelessness, substance abuse, severe psychosis, and post-traumatic stress disorder. These conditions often feed on each other and providers must coordinate responses to best treat the underlying roots of the veteran's psycho-social disorder.

VA, like other psychiatric providers that care for the chronically mentally ill, relies heavily on custodial care. Caring for this population's basic needs is essential. Without the programs provided by VA, chronically mentally ill veterans often lacked food, shelter, or adequate clothing. Alcohol or drug use is often a substitute for rehabilitation to alleviate the veteran's pain and confusion.

In addition to the important custodial care these facilities offer veterans, VA runs programs which rehabilitate mentally ill veterans and allow them to regain their independence. Along with 30 VA medical centers specifically designated as long-term psychiatric care facilities, VA administers intensive psychiatric community care programs, psychiatric transition wards, adult-day care centers, and mental hygiene clinics. These VA programs often successfully rehabilitate mentally ill veterans and allow them to regain their independence. One of the most important aspects of these programs is that they encourage development of independent living skills for the less impaired veteran who might otherwise be "warehoused." Unfortunately, due to budgetary constraints, there are waiting lists for enrollment in these programs. We believe VA should establish short-term care settings with more intensive therapy to augment its services to the chronically mentally ill. In order for VA to better serve the chronically mentally ill, we believe it should develop innovative psychiatric care programs in less restrictive settings and expedite veterans return to the community.

Mr. Chairman, one of the most shameful statistics indicate that from one-third to one-half of our nation's homeless are veterans—mostly Vietnam-era service persons. VA itself estimates that the number of homeless veterans could be as high as 250,000. Many of these veterans are mentally ill and exhibit compounded problems. Substance abuse often accompanies these mental illnesses and, by some estimates, two-thirds of VA's homeless patients are treated for addiction to drugs or alcohol. VA has stated that up to 45 percent of sampled veterans enrolled in homeless chronically mentally ill programs have also serious medical conditions.

One area of concern is the fact that VA may be releasing mentally ill patients from medical facilities too soon or not providing the patient with adequate support facilities. While many veterans respond well to treatment within a long-term psychiatric care facility, it is just as important that they continue their medication in a consistent manner when discharged. In many cases, this is not happening. The veteran either ceases to take his medication or, in some cases, sells or trades his medication in order to purchase alcohol or non-prescribed drugs. The end result is a rapid deterioration of the progress attained as a patient in a long-term psychiatric care facility. VA should expand homeless veterans programs that focus on enhancing a veteran's independent living skills. Expansion of programs such as drop-in centers, compensated work therapy/therapeutic residence programs, domiciliary care for homeless veterans programs, VA supported housing programs, and comprehensive homeless centers should receive serious consideration.

Mr. Chairman, another serious problem manifesting within the veteran's community is post-traumatic stress disorder. This has become increasingly prominent in the 80's and 90's. The National Vietnam Veterans Readjustment Study, which the Research Triangle Institute conducted, found that 15.2 percent of the 3.4 million Vietnam-era veterans may experience PTSD. Also, according to this study, approximately 500,000 Vietnam-era veterans may respond to treatment for PTSD. Currently VA administers several programs for veterans suffering from post-traumatic stress disorder. These include post-traumatic stress disorder residential rehabilitation programs, POW support groups, joint post-traumatic stress/substance abuse disorders units, and readjustment counseling.

While Congress has been sympathetic to the needs of veterans with PTSD by adding funding for PTSD in-patient/out-patient care programs, research, PTSD clinical teams, and a PTSD national center, VA must continue its progress in treating veterans with PTSD. Persian Gulf war after-effects may compel those veterans with re-

cent combat experience to seek help; VA must target eligible veterans and address their specific needs.

Mr. Chairman, the VFW believes VA has made great strides in its treatment programs of the chronically mentally ill. Its research role in the treatment of the chronically mentally ill is highly respected and considered essential by experts in the field. In fact, the VA's research capability is so well regarded that the National Institute of Health contributes financially and materially to its efforts. Considering the resources VA has been provided, they are doing an excellent job. However, it has to be noted that considering the work load facing VA, they are still under funded and under staffed. While nursing staff levels have slightly improved, there is still a shortfall in the intensive care and the critical skill level. While funding is, of course, critical to the success of any program, the care of the chronically mentally ill relies solely on dedicated professionals committed to treating the needs of a highly deserving and vulnerable component of the veteran population. Recruitment and retention of these highly specialized health care professionals must be established as a priority within the Department of Veterans Affairs.

Mr. Chairman, in your letter of invitation you also requested that we comment on two legislative proposals. S. 1226, introduced by Senator Daniel Akaka, a member of this distinguished committee, would amend title 38, United States Code, to provide for the organization and administration of the Readjustment Counseling Service (RCS) as well as to improve eligibility for readjustment counseling. Specifically, S. 1226 would make the Readjustment Counseling Service (better known as Vet Centers) a permanent, statutory service within the Department of Veterans Affairs; raise the status of the RCS Director; expand eligibility for RCS services; preserve the confidentiality of RCS records; make improvements to the Advisory Committee on the Readjustment of the Vietnam and other war veterans; expand the Vietnam Veterans Resource Center's pilot program; and establish a pilot program authorizing the provision of primary health care services at Vet Centers.

The VFW has recognized the crucial role Vet Centers have played in returning veterans to the mainstream of society. While originally conceived as a program exclusively for Vietnam veterans, its value has been recognized to the point where it now serves veterans of other conflicts as well. The VFW supports the provisions of S. 1226 and encourages its enactment into law.

Mr. Chairman, we were also asked to comment on a draft proposal introduced by you that would require the establishment of mental illness research, education, and clinical centers within the Department of Veterans Affairs. As stated in our testimony, the VFW believes VA has made great strides in its treatment of the chronically mentally ill. However, we also believe that much more can and must be done in this critical area. The VFW believes the draft proposal introduced by Chairman Rockefeller is an excellent step in enhancing VA's ability to care for the chronically mentally ill.

While the VFW supports the thrust of this draft proposal, we do not believe that clinical and scientific investigation activities should be in competition with other research programs for funding dollars. While similar language is contained in title 38 with respect to prioritization, it is our understanding such language has been enacted in order to get proper funding for newly emerging medical fields. The treatment of mental illness certainly is not an emerging medical field and we do not support the granting of priority of one research program over another when competing for funding dollars.

This concludes my statement and I will be happy to respond to any questions you or members of the committee may have.

PREPARED STATEMENT OF DR. ALFONSO R. BATRES, REGIONAL MANAGER, READJUSTMENT COUNSELING SERVICE, WESTERN MOUNTAIN REGION 4A, DENVER VET CENTER, AND CHIEF CLINICAL MANAGER—WEST

Mr. Chairman and members of the committee, it is truly a pleasure for me to have the opportunity to be here today to brief the members of this committee on the activities of the Readjustment Counseling Service Western Mountain Region.

The mission of the Readjustment Counseling Service Western Mountain Region is to lead a high quality and accountable administrative and clinical system of regional vet centers which provide readjustment counseling to Vietnam era veterans; veterans of conflicts in Lebanon, Grenada and Panama; veterans of the Persian Gulf War; and women veterans who were sexually traumatized during military service; as well as to ensure that each vet center maintains high quality clinical and admin-

istrative standards in compliance with Readjustment Counseling Service and Department of Veterans Affairs policies.

The Western Mountain Region covers the largest geographical area of the seven Readjustment Counseling Service regions. The region encompasses a ten state area reaching from New Mexico to Alaska and employs 100 full-time employees. The region has been augmented with 4.3 full-time employee equivalents (FTEE) for outreach to veterans of Operation Desert Storm and 4 FTEE for outreach and counseling services to women veterans suffering from the effects of sexual harassment or assault during their military service.

The Western Mountain Region provides readjustment counseling services to veterans via 26 vet centers and 34 community mental health providers, under contract, providing services at 59 community locations. Many of our vet centers are located in rural areas such as Missoula, Montana and Fairbanks, Alaska, often representing the only Department of Veterans Affairs presence in those communities. Due to its large geographical area, the Western Mountain Region must focus on the delivery of services to rural, hard-to-reach populations. Our employees use a variety of methods to outreach and serve these widely dispersed populations.

Some examples of these methods are the annual attendance by our vet centers in the Pacific Northwest (Seattle, Spokane and Tacoma, Washington) at Camp Chaparral on the Yacoma Indian Reservation, the out-stationing of the Women Veterans Sexual Trauma Counselor from the Boise, Idaho Vet Center at the local YWCA, and the work of the Casper, Wyoming Vet Center with the Central Wyoming Rescue Mission in providing assistance to homeless veterans.

One particular project on which I would like to focus your attention is our one-person vet center outstation on the Hopi Indian Reservation in northern Arizona. Mr. Cliff Balenquah, Counselor at the reservation, will provide some insight into this special outreach effort. In addition, Readjustment Counseling Service has formed the Rural Working Group, a new national working group, the operation of which I oversee, to study the unique characteristics of service delivery to dispersed rural populations utilizing limited resources. Mr. Mike Loy, Team Leader of the Reno, Nevada Vet Center, is the chairman of the Rural Working Group and will provide testimony regarding the general delivery of services to rural areas.

PREPARED STATEMENT OF DR. JOE GELSOMINO, REGIONAL MANAGER,
SOUTHEAST REGION, READJUSTMENT COUNSELING SERVICE, BAY
PINES, FLORIDA

Thank you for the opportunity to speak to you today. I would like to describe the services provided by the Vet Centers in the southeastern United States.

Readjustment Counseling Service (RCS) provides a variety of services aimed at assisting veterans of the Vietnam Era and post-Vietnam Era who are having difficulty adjusting to civilian life as a result of their military experience.

The Southeast RCS Region consists of 25 Vet centers and 2 satellite centers within the following locations: Mississippi, Alabama, Florida, Georgia, North Carolina, South Carolina, Puerto Rico and the U.S. Virgin Islands.

Vet Centers see many veterans who exhibit symptoms of Post Traumatic Stress Disorder (PTSD) resulting from trauma incurred while serving in the military. Because the effects of trauma are often delayed, a veteran may not associate it with being in the military. By the time an affected veteran is seen at Vet Centers, he or she most likely will have experienced many of the classic symptoms of PTSD. The veteran may be chronically unemployed, have had multiple marriages, numerous psychiatric hospital admissions, or other personal problems such as rage and impulse control, hypervigilance, extreme guilt, which may or may not include substance abuse.

The Vet Centers provide a range of services to include problem assessment and counseling and psychotherapy to veterans and their families. We also assist with concrete needs such as food and shelter for homeless veterans. Recently we have added services for women veterans who have been traumatized as a result of sexual abuse experienced while in the military. Rural veterans who often cannot access readjustment services, due to living in areas distant from VA facilities, are provided services through our Fee Contract Program—a network of private sector therapists under VA contract.

Vet Centers provide outreach to veterans who may not know of the services to which they are entitled. Vet Center staff often visit places veterans frequent and provide services in clinically non-traditional settings in the community. When the needs of the veteran are beyond the scope of readjustment counseling they are referred and linked to other VA or community resources.

The Vet Center staff have collaborative relationships with clinical services at VA medical centers and outpatient clinics. Reciprocal referrals with VAMC's substance abuse, Post Traumatic Stress Disorder Clinical Team/Stress Recovery Unit (PCT/SRU), and psychiatric services are ongoing.

PREPARED STATEMENT OF DR. SUSAN A. ANGELL, REGIONAL MANAGER, PACIFIC WESTERN REGION, READJUSTMENT COUNSELING SERVICE, SAN FRANCISCO, CALIFORNIA

I am currently the Regional Manager for the Readjustment Counseling Service Pacific Western Region.

As Regional Manager, I am responsible for the clinical and administrative functions of thirty-one Vet Centers located in California, Oregon, Hawaii, and the Territory of Guam. My duties also include oversight of the Asian American/Pacific Islander Working Group, membership on VA's Task Force on Sexual Trauma, and Chairing the Readjustment Counseling Service Transition Committee for Sexual Trauma Counseling.

The Vet Centers provide readjustment counseling to veterans of the Vietnam era and to combat veterans of the conflicts in Lebanon, Grenada, Panama, and the Persian Gulf. Most recently, services have been extended to female veterans of all eras who experienced sexual harassment or assault while serving on active duty.

Six Vet Centers within the Pacific Western Region have been assigned additional staff to specifically outreach to Persian Gulf veterans. Since eligibility was expanded, the region has outreached and provided services to over 9,620 Persian Gulf veterans and their families.

Eight Vet Centers within the Pacific Western Region have been assigned staff to outreach and treat women veterans who experienced sexual trauma while on active duty. The Pacific Western Region designed and implemented a survey which was used nationwide in Readjustment Counseling Service and brought to light the prevalence of sexual trauma within the female clientele currently being seen at Vet Centers.

In addition the region has also responded to disasters such as the Loma Prieta Earthquake, the Oakland Firestorm Hurricanes Iniki in Kauai HI and Omar in Guam, and the Los Angeles Riots. During these disasters RCS mobilized counseling resources, outreached to traumatized individuals, and provided crisis debriefing as needed to individuals and other health care providers.

PREPARED STATEMENT OF DR. WILLIAM A. WEITZ, TEAM LEADER, READJUSTMENT COUNSELING SERVICE, PALM BEACH, FLORIDA VET CENTER

I wish to express my appreciation to the committee for inviting me to provide input on the Department of Veterans Affairs, Readjustment Counseling Service. As a licensed clinical psychologist and an original Vet Center Team Leader, I would be pleased to respond to issues regarding the diversity and quality of services provided by my center.

The Palm Beach Vet Center is an expansion facility which was established in March 1985. Located in the geographical center of Palm Beach County, Florida. We provide outreach, referral, and counseling services to eligible veterans in five County area, with medical support provided by the Riviera Beach Outpatient Clinic and the VA Medical Center in Miami. While the environment in which the center is located would be described as suburban, a significant number of our clients have adapted to a rural lifestyle. Since the establishment of our center, we have provided services to approximately 2,000 separate veteran, with an average weekly workload of 75 client visits, and approximately 30 new veteran clients monthly.

Clients seeking services at our center have manifested diverse problems, with the greatest number seeking employment and benefits assistance, psychological counseling for combat-related stress disorder, alcohol and drug treatment, and counseling for marital and family conflicts.

Given the education level and professional background of Palm Beach center staff, our facility has been oriented to providing high quality diagnostic and treatment services for clients seeking psychological assistance. It is, thus, significant that a high percentage of our clients are engaged in direct clinical services, to include: individual, peer group, or marital therapy. Additionally, outreach efforts to correctional facilities and north county areas have expanded center functions to reach veterans who have had limited access to veteran programs.

Supplementary to the basic Vet Center staffing pattern of Team Leader, two counselors and an office manager, the Palm Beach Vet Center has assisted primary staff

with a Disabled American Veteran (DAV) volunteer claims and benefits counselor, two Disabled Veterans Outreach Person (DVOP) from the Florida Job Service, a veteran work study student and senior volunteers. Through the part-time work of these personnel, we have been able to provide increased services to our client population. Further, we have found that the staff diversification as to age, race, and gender has resulted in positive acceptance by our veteran clients.

Throughout my 11-year tenure as RCS Team Leader, I have seen the Vet Center program undergo significant change. However, it has been the quality of service delivery and the dedication and motivation of Vet Center staff which has enabled our program to reach both high levels of Performance and productivity.

PREPARED STATEMENT OF STEPHEN T. MOLNAR, TEAM LEADER, HONOLULU, HAWAII VET CENTER

Stephen Molnar, a Vietnam veteran, has been the Team Leader of the Honolulu Vet Center since its establishment in 1979. The Honolulu Vet Center is located in central Honolulu on the island of Oahu, the populous of Hawaii's eight major islands. The population of the State is cosmopolitan, with approximately 70 percent being classified as non-Caucasian.

The Honolulu team consists of five full-time employees: two permanent counselors, one temporary Persian Gulf counselor, an office manager and the Team Leader. All staff have graduate degrees and all are veterans, two of which served in Vietnam. A quarter-time social worker has recently been hired for the newly authorized "Women's Program" and will be officially on duty during the second week of August 1993. The Honolulu Vet Center also has a full-time Disabled Veterans Outreach Program offering computerized employment, training and placement services. Additionally, service officers from the Disabled American Veterans and the Military Order of the Purple Heart are outstationed twice weekly to assist veterans with disability and claims issues.

Since the center's official dedication in May 1980, the Honolulu Vet Center has provided services to more than 6,000 eligible veterans. Prior to the establishment of neighbor island Vet Centers in 1988, the Honolulu center provided readjustment counseling to outer island veterans via the Readjustment Counseling Service Contract Fee Program. At present, there are five Vet Centers in the State; one each on Oahu, Kauai, and Maui, and two on the island of Hawaii.

The Honolulu Vet Center serves a diverse and multi-cultural population offering outreach, assessment, psychological and employment counseling, referral services, and educational and community activities. Currently, five therapy groups and one employment group are offered. With almost 9,000 returning Persian Gulf veterans to Hawaii, we have an active outreach, counseling, employment and follow-up program established to serve this population. Other groups periodically offered include; Anger Management, Sleep Disorder Clinics, Life Skills Training, Family Alcohol Education, Couples Therapy, and Smoking Cessation.

Staff of the Honolulu Vet Center have received recognition for their efforts with veterans from the U.S. Senate, the Hawaii State Legislature, the Honolulu City Council, The American Legion and the Veterans of Foreign Wars. In 1988, a staff member received the Department of Veterans Affairs coveted "Hands and Hearts" Award. Additionally, staff have been appointed to serve on important governmental bodies to include the Governor's Employment and Training Council, the State HIV Task Force, the State Homeless Task Force, and the Hawaii Health Care Task Force.

The Honolulu Vet Center has made significant contributions to Hawaii's veteran community through numerous other activities. These include: coordinating three state-wide conferences on PTSD, co-editing a publication entitled "Employment Benefits for Veterans in Hawaii," co-authoring a published article on Asian Veterans, participating in several veteran research projects, helping to establish the "Hawaii Vietnam Veterans Leadership Program" initiating the first annual "Candlelight Memorial Service" at Punchbowl National Cemetery establishing one of the first PTSD groups at a military hospital, bringing the replica of the "Vietnam Memorial Wall" to the State Capitol, and working with the State Legislature in its passage of significant veterans legislation included the nation's first full university tuition waiver for Vietnam veterans, a Korean and Vietnam State Memorial, and a State of Hawaii Agent Orange Research Project.

PREPARED STATEMENT OF CLIFFORD BALENQUAH, COUNSELOR, READJUSTMENT COUNSELING SERVICE, HOPI RESERVATION, PRESCOTT, ARIZONA VET CENTER

Mr. Chairman and members of the Committee, I am pleased to be here today to brief the members of this committee on the activities of the Hopi Reservation.

The Hopi Vet Center Outreach Office is a unique operation being that it is one of the first of its kind located directly on an Indian Reservation and is staffed by Tribal members knowledgeable in cultural heritage and speak the native language. This Outstation serves the entire Hopi Reservation and portions of the Navajo Nation, the White Mountain Apache and San Juan Southern Ute tribal areas, an area which covers 65,500 square miles. American Indians (approximately 300 different tribes) have served in the Armed Forces in large numbers, with 10 percent of all living American Indians being veterans.

I live on the Hopi Reservation where I am available 24 hours everyday to assist and provide immediate service. I am fluent in speaking the Hopi language and participate in our Tribal religious ceremonies. I understand and speak the Navajo language with limitations. I am a federal employee and member of the Hopi Tribe, a federally recognized Indian Tribe, which enjoys a sound government-to-government relationship with Department level personnel of our Nation's government. I am part of the Prescott Vet Center team, and my coordination with the team is excellent and their understanding and availability is extremely efficient. Although my office is 236 miles from Prescott, the cooperation of everyone has been overwhelming, which makes my mission a pleasurable task.

Indian tribes are culturally diverse, although many of the principle beliefs remain constant. This makes it advantageous for a native speaking, culturally knowledgeable person to be employed who can relate to these language differences, religious ceremonial differences, and the differences in combat-related (PTSD) healing ceremonies coupled with tribal beliefs and taboos (i.e., it is taboo for Navajos to give or receive a blood transfusion, as the original blood owner will eventually reclaim his/her own blood), and provide services directly on the Reservation.

There are numerous examples of cultural barriers to V.A. care regarding Native American veterans. A Hopi veteran being questioned by a Physician nodded in agreement which pleased the smiling, nodding Physician. Unknowingly, the veteran only picked up bits and pieces of the English language. I then intervened and asked the veteran in the Hopi language if he understood what he was answering to, his reply was "No." I asked why he was nodding to indicate a "yes" answer. His reply was that the Physician was speaking too fast and was nodding as he spoke to him. I then interpreted the questions to him in Hopi and many answers had to be changed. An Apache Vietnam combat vet continued to see striking resemblance between the Vietnamese and himself, particularly in body size and skin coloring, which an Anglo counselor saw as insignificant.

There are other barriers, such as few facilities are located near Indian Reservations, the distance is usually great, reliable public transportation and communication services are lacking, distrust of the Federal Government due to past broken treaties, cultural misunderstanding of special Native American needs, and non-veteran counselors who cannot relate to the traumas of combat, etc. There are high rates of post-war psychosocial problems among Indian veterans, and having Indian veteran counselors enhances the readjustment transition back into tribal society and Bahana's (Anglo) society, and a Reservation environment enhances the recovery process. Few studies, if any, are available on the American Indian combat veteran and the interplay of PTSD and cultural compositions. Tribal Clan structure and the extended family clan system are vitally significant to the Warriors' homecoming and the readjustment process. Because warriors have fought battles, they should not only be honored, but also purged of the taint of battle and restored to a harmonious place within their community.

Tribal religious practices are sometimes viewed as primitive by those unfamiliar with Indian culture, but these practices have been done for hundreds of years and they are effective for Indian veterans. I have witnessed the process, participated in the traditional healing, and I know veterans who have become productive citizens again based on these practices. Outreach is necessary for other purposes such as promoting the Indian Vietnam and other veterans in a positive image, promoting and providing ways to express pride of their warrior status, promoting unity in Tribal and Federal Government concerns, and in remembering those brothers and sisters who have paid the supreme sacrifice.

PREPARED STATEMENT OF MICHAEL LOY, MSW, TEAM LEADER,
READJUSTMENT COUNSELING SERVICE, RENO, NEVADA VET CENTER

Mr. Chairman and members of the Committee, I am pleased to be here today to brief the members of this committee on the activities of the Reno, Nevada Vet Center.

The Reno Vet Center has been in operation since April 1981, and provides services to Vietnam Era and Post-Vietnam Combat/Conflict veterans, and Women veterans suffering from sexual harassment and/or assault.

One of the strengths of the Vet Center program comes from the small team structure. Within that structure clinical team members have the freedom to develop creative solutions to problems that are specific to the populations and communities being served. Examples of these creative solutions are the development of services to urban homeless veterans. Through cooperative efforts among the veteran service organizations, community services, and Vet Center staff, housing and job training programs have been developed. Stand-downs reaching out to provide immediate and meaningful assistance to homeless veterans is another example of innovative assistance to homeless veterans, many of whom suffer from chronic mental illness. During stand-downs the whole community is organized to provide a wide range of social services to those in need.

Native Americans living on Reservations are being served through the Vet Center program by bringing services to them directly. Other rural veterans are also in need of services, and strategies to provide services to them are currently being developed through a Readjustment Counseling Service Special Working Group searching for ways to provide access to care.

Quality clinical care is provided by the Vet Center Program through continued efforts of reaching out to unserved and underserved veterans in both urban and rural populations by locating veterans in need, providing immediate assistance when possible, and referring veterans to a VA Medical Center or Outpatient Clinic or community resource when necessary. The Vet Center is able to assist in providing a continuum of care for those veterans in need of service.

In conclusion, the very nature of the Vet Center mission and structure makes it possible to be responsive and innovative in providing outreach and clinical services to the veterans we serve.

PREPARED STATEMENT OF DR. DANIEL G. DOYLE, TEAM LEADER,
RICHMOND, VIRGINIA VET CENTER

PREFACE: I view the chronic nature of PTSD from two perspectives: First, the chronicity of individual symptoms such as nightmares, flashbacks, etc., and second, the chronicity of attitude problems, specifically that most Vietnam veterans I know feel betrayed and abandoned by the country they served and often focus these feelings on the government which represents the people. Very active working relationships with mental health staff of McGuire VA Medical Center have always been an essential part of our programs.

CURRENT PROGRAMS CLINICAL SERVICES: The Richmond Vet Center offers the full range of individual, group, family, and marital therapy as well as formal diagnostic evaluations for VA and Social Security disability. At the present time, we offer three weekly PTSD groups for veterans and one weekly group for significant others (one-fourth to one-third of visits are with family members). These are all offered in the evenings to be accessible to working veterans and spouses. One of these groups is limited to black veterans and specifically addresses racial issues. We are developing a daytime group for unemployed veterans recently discharged from the psychiatric or substance abuse ward, beginning sometimes in September. This group will meet at the Vet Center, with one co-leader being a Vet Center counselor and one co-leader being a psychologist from the VA Medical Center. The continuing involvement of staff from both facilities promotes continuity of care by bridging the gap between in-patient and outpatient treatment and directly counters the attitude of many veterans that they are being "shuffled" from one program to another.

TRAINING: At present, we are accredited by Virginia Commonwealth University (VCU) and The Medical College of Virginia (MCV) to provide the following training: one year internship for pre-doctorate psychologists and masters degree students in Social Work, Vocational Rehabilitation, and psychiatric nursing. We are also accredited to provide group therapy training to 3rd year psychiatry residents. Utilization of this training has been extensive. In the last 4 years we have averaged 5 students per year: 2 MSW interns, 2 psychology interns, and one psychiatry resident. Various Vet Center staff also educate by conducting seminars, workshops, etc., at VCU, MCV, and various professional conferences.

PREVIOUSLY EFFECTIVE PROGRAMS: "Staff Sharing"—in previous years the Vet Center negotiated joint programs with the Medical Center's inpatient psychiatric and substance abuse wards. A Vet Center counselor co-lead a weekly group with inpatient staff on the inpatient wards. At the same time, a nurse from the inpatient wards co-lead a weekly group at the Vet Center. These joint programs were terminated several years ago due to shortage of nursing staff. The working relationships continue, but in a less formal way.

FEMALE VETERANS: Five years ago, the Richmond Vet Center offered a six month program of group therapy for female nurses from Vietnam. Although quite effective, our usual services for female veterans is individual counseling since we seldom have enough female veterans at one time to offer group.

PREPARED STATEMENT OF CLYDE POAG, TEAM LEADER, GRAND RAPIDS, MICHIGAN VET CENTER

Chairman John D. Rockefeller and Members of the Committee on Veterans Affairs, thank you for inviting me to the Senate Committee hearing. My name is Clyde Poag. I am the Team Leader at the Vet Center in Grand Rapids, Michigan. I am also Chairman of the Readjustment Counseling Service (RCS), African American Working Group.

The Grand Rapids Vet Center, in cooperation with local community agencies, is involved in a collaborative effort to provide services to homeless veterans. Our community was awarded a grant by the Department of Housing and Urban Development called Shelter Plus Care. The grant provides a rent subsidy for 30 homeless veterans.

It has been estimated that one-third of homeless people are veterans. Our program provides stabilized housing and a wide range of services including readjustment counseling, vocational rehabilitation services, and employment assistance.

Veterans accepted into the Shelter Plus Care program are afforded stabilized housing for as long as 10 years. Presently, here are 27 veterans in the program, the majority of whom are Vietnam and Vietnam era veterans. At this time, we have 1 veteran of Operation Desert Storm in our program. The veterans in the program have been diagnosed with a wide array of readjustment problems including: chronic mental illness, substance abuse, and Post Traumatic Stress Disorder. These veterans are alienated from family and friends and become homeless due to their condition.

The three criteria for acceptance into the program are that the veteran (a) be homeless; (b) have a disability; and, (c) have an acceptable discharge. The veterans are seen in individual and group counseling. Benefits and employment counselors, as well as rehabilitation and recreational specialists, are available to assist those veterans. In addition, the veterans have access to all of the YMCA facilities, including the health club and exercise facility. Presently, several of the veterans are employed on a part-time basis and 5 have enrolled in local colleges.

This program is successful because of the cooperation between the VAMC in Battle Creek, the VA Outpatient Clinic in Grand Rapids, county mental health agencies, and the local Emergency Shelter Task Force. Our program has been used as a model by other communities in their efforts to provide services to homeless veterans.

As in the general population, a large percentage of homeless veterans are African American. This is also true for our program, in which more than half of the men are African Americans. The National Vietnam Veterans Readjustment Study showed that African American veterans experience high levels of PTSD, as well as other readjustment problems. The RCS Working Group on African American Veterans is concerned about these and other issues that need to be addressed. The Grand Rapids Vet Center is striving to meet the needs of this group of veterans along with our other clientele.

Thank you. I will be happy to answer any questions.

STATEMENT OF MICHAEL F. BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. Chairman, thank you for this opportunity to testify on your draft bill to improve VA mental health research as well as S. 1226, a bill that would make significant improvements in the VA's Readjustment Counseling Service.

The draft bill contains several requirements to be considered by the Secretary when designating individual mental health research and training centers. AMVETS would like to suggest the addition of a seventh criteria that would include formal

working relationships with Vet Centers, Vietnam Veteran Resource Centers and VA PTSD centers. That would help to ensure a flow of information from the health professionals and social workers in the trenches to the centers of excellence regarding the problems faced by veterans. In return, the mental health centers could act as resource centers by providing information to the grassroots on the latest advances in treatment. It would also help keep the focus of research on problems unique or highly prevalent in the veteran community.

AMVETS strongly supports the bill, and we urge its passage.

S. 1226 is an excellent bill. Section 2 freezes the current internal RCS organizational structure and requires VA to provide Congress with a 60 day notification of proposed changes. We strongly support this provision because it will prevent VA from reorganizing the RCS out of existence. We all know of the past attempts to put the Vet Centers under the control of nearby VA Medical Centers (VAMC) or physically move them into VAMC facilities. We support this provision because it is important to retain the storefront character of the Vet Centers to continue to attract those who normally shun VA treatment. We also support the 60 day notification clause because it is a reasonable approach to change.

We are also pleased to see the requirement for the VA budget submission to show the amount requested for the RCS and the Advisory Committee. AMVETS suggests that language be included to provide clear authority to reimburse Advisory Committee members for administrative expenses beyond per diem and travel.

We applaud the provisions in Section for that will authorize Vet Centers to extend counseling to all veterans, regardless of when they served. PTSD is not unique to those who served in Vietnam, and it is time the government took responsibility for all those who continue to suffer because of service-connected trauma. AMVETS also supports the provisions to provide bereavement counseling to the families of those killed on active duty or die from a service-connected condition. We hope the presence of both veterans and parents in group counseling sessions will have a positive impact on the length of time required for counseling. The bill sets no time limit on bereavement counseling and maybe that is appropriate. We do not envision Vet Centers being overwhelmed with family members but it is important to not lose sight of the primary beneficiaries—the veterans.

AMVETS strongly supports the confidentiality provisions in Section 5.

Section 6 codifies the Advisory Committee on Readjustment Counseling and requires the Secretary to seek its advice. AMVETS suggests that the Assistant Secretary of Labor for Veterans Employment and Training, and appropriate representatives form the Office of Personnel Management, the Department of Education and the Department of Health and Human Services be appointed as ex-officio members. This should provide the committee with a sufficiently broad cross-section of the veteran community and government to provide competent advice on how to best help veterans with problems adjusting to civilian life.

Section 7 expands the Vietnam Veteran Resource Center pilot program, commonly called the Super Vet Centers. Expansion of the one-stop-shopping concept makes eminent sense. With the addition of the bill's pilot program to provide limited healthcare at vet centers, VA will take a significant step in expanding the concept of preventive medicine to a group of veterans who often live on the edge of homelessness. By providing early intervention through basic health screening and lifestyle counseling, VA may be able to prevent hospitalization. AMVETS has long supported a more grassroots approach to VA medicine and this is surely a right step in that direction. We suggest that strong consideration be given towards language that would link this legislation to previous legislation offered by this committee for expanded rural health care and mobile treatment units. As a package, the three bill offer an opportunity for real improvement in medical services for those who are now largely ignored by the medical community.

AMVETS would like to offer one final thought regarding this legislation and VA eligibility reform. It is obvious that if VA is to succeed under managed competition, it must move toward a more regionalized structure, with centers of excellence such as proposed by the Chairman's draft bill, a concentration on what it does best, and finally a more grassroots approach to the delivery of basic care. The objective of national health care reform is to provide every citizen access to a basic package of care. But without significant financial incentives, it is unlikely the private sector will be quick to improve service to the rural and inner city areas that are traditionally underserved. Therefore it is important that VA begin the adjustment to better serve veterans in these areas.

Mr. Chairman, to summarize, AMVETS supports both your draft bill and S. 1226 because they move VA in the right direction to compete under national health care and should improve the delivery of health care and counseling to the veteran community.

STATEMENT OF WILLIAM F. CRANDELL, LEGISLATIVE ADVOCATE,
VIETNAM VETERANS OF AMERICA

DISCUSSION

Mr. Chairman and members of the Committee, Vietnam Veterans of America (VVA) is pleased to have the opportunity to present its views on the important topic of VA mental health care, and to voice our strong support for both S. 1226, Senator Akaka's Readjustment Counseling Service Amendments of 1993, and the Rockefeller draft bill to create centers for mental illness research, education and clinical activities.

VVA will discuss several aspects of the issue. The first will be VA mental health care in a national health care setting. The second will be the mental health care aspect of the VA's general problem of providing quality care. The bulk of our testimony will focus on Post Traumatic Stress Disorder (PTSD), the least understood mental health problem addressed by the VA today. In considering how PTSD is handled and how it needs to be handled, we will discuss what needs to be done with the one existing alternative to long-term care that has had such significant success to date, the Vet Center program, and its relationship to the rest of the VA. We shall also examine the in-and-out nature of PTSD patients, and the ongoing need to correct VA's bias against claims for compensation of PTSD, which results in much higher utilization of long-term care than is necessary.

VA MENTAL HEALTH CARE IN THE AGE OF NATIONAL HEALTH CARE

Perhaps the most challenging issue facing the organized veterans community right now is the shape VA health care will take once some form of national health program is adopted. The outcome of that debate will have a major impact on care of the chronically mentally ill.

Will such reform open the doors of both private and state facilities to patients who now have no option other than VA care? As we noted in our testimony of April 27 of this year before this Committee, the two leading health reform designs are "managed competition" and "single payer" programs. Of these, "managed competition" is the design President Clinton has embraced.

The VA can ill afford to ignore any longer the fact that the advent of national health care offers veterans currently dependent upon VA the first hope of exercising choice in deciding where to secure health care. Like other consumers, veterans will go for care where they can most conveniently be treated in a manner meeting their expectations of quality. This will be no different for the chronically mentally ill, whether they are capable of making their own decisions or these choices are made by family members.

THE QUALITY OF VA MENTAL HEALTH CARE

Under either "managed competition" or "single payer," it is clear enough to us that many veterans currently dependent upon the VA for health care would opt out of VA if a more accessible option with perceived higher quality were available. For the chronically mentally ill veteran user of the VA health system, as with any other VA-dependent user, quality is best defined as being seen at appointments on time by courteous and competent professionals, being subject to a minimum of invasive procedures designed to satisfy teaching needs and by being reasonably assured of timely and successful treatment. The consensus of veteran users of all forms of VA health care—right or wrong—is that quality is deficient.

One of the most cherished freedoms at the heart of the debate on national health care reform is the right to choose one's own primary care physician. We would call your attention to a recent article in the Washington Post (July 20, 1993) by Dr. Arnold S. Rothman, professor of medicine and social medicine at Harvard and editor-in-chief emeritus of the New England Journal of Medicine, in which he commented:

The one-fourth of Americans who live in rural areas rarely have access to more than a few primary care physicians—often only one. In more populated areas, the uninsured and the poor have little or no choice of doctor.

The same is true for active members of the armed forces and patients in the Veterans Administration.

There are a variety of things the VA does as well or better than the private sector. These include long term mental health care, substance abuse treatment, outpatient treatment of PTSD through Vet Centers and even inpatient PTSD treatment in those hospitals which are serious about treating PTSD. These programs should be expanded through bed conversion. Legislation mandating bed conversions using a

phase-in mechanism should be developed and enacted once the specific shape of a national health program becomes clear.

POST-TRAUMATIC STRESS DISORDER TREATMENT AND RESEARCH

Post-Traumatic Stress Disorder is perhaps the most common major contributor to chronic mental illness among veterans of any generation. According to the highly respected National Vietnam Veterans Readjustment Study (NVVRS), published in 1988 by the Research Triangle Institute, nearly half a million men and women who served in Vietnam suffer from full-blown PTSD. It is a chronic disorder in itself, not limited to Vietnam veterans but afflicting those who served in every war, as well as people who have experienced a wide variety of other traumatic stresses. NVVRS found those with PTSD likely to experience other specific psychiatric disorders. Although many veterans with PTSD have not yet sought treatment, they are more likely to seek VA care than veterans who do not suffer this disorder.

THE NEED FOR NEW LEGISLATION ON PTSD

The importance of enacting legislation to broaden VA treatment of PTSD is that so little has been done by the VA of its own accord to address the magnitude of the PTSD epidemic. Similarly, it is critically important that veterans with PTSD who are treated in VA general psychology or psychiatry inpatient, outpatient or other clinics lacking expertise in PTSD be treated for the proper disorder. Today no such guarantee of proper treatment exists.

Even when the veteran is able to access VA care, PTSD is often misdiagnosed. VA needs to recognize and implement procedures to ensure that veterans needing PTSD care are recognized properly and treated appropriately. Far too frequently, the VA looks at PTSD and sees instead only the substance abuse that is so often a tell-tale symptom of PTSD, branding the symptom "willful misconduct" and refusing to diagnose the disorder itself. And the notion that PTSD, where it is detected, is not service-connected, but merely the outgrowth of some hypothetical childhood instability, is still too prevalent in a veterans health care system that has been seeing veterans return from war for half a century with these symptoms.

S. 1226 recognizes the research already done on the issue of PTSD and embraces improvements in access to service and modalities of treatment. The Rockefeller draft bill provides a vehicle for disseminating both research and practice derived from it throughout the VA, where it is anybody's guess which facility is a up-to-date on what. Passage of these two bills would move the VA closer to acceptance of a medical mission to provide the range and type of PTSD care that is presently lacking in both the VA and private sectors. Still, we must ask a cautionary question: Will the mental illness research, education and clinical centers (MIRECs) that this bill would create be used to justify ignoring PTSD in order to train for treatment of more exotic illnesses?

As we noted in our April 27th testimony, the VA is treating only about 10% of those veterans whose military service resulted in PTSD, whether this service occurred during or before the Vietnam War, in Operation Desert Storm, or in the day-to-day routine of military operations. Not only has the demand for program services been ignored by VA in the past, but the success of those existing programs have often been threatened by "departmental reorganization" efforts and funding cuts. The most recent example is that of the Vet Center program. In addition, specialized PTSD services, like that of VA health care in general, are sparse and may be located at an inaccessible distance from the veteran.

It is important to note in passing that the VA is only beginning to recognize that women can be affected by PTSD, too. One step that still needs to be taken is the adoption of legislation which calls for broadening the context of service-connected Post-Traumatic Stress Disorder to include the aftermath of sexual trauma. And with more women flowing into the military, whether or not their combat roles are expanded, we can already expect women to swell the ranks of veterans with service-connected stress problems. The general shortage of VA readiness to accommodate women patients in the VAMCs is reflected in psychiatric facilities as well.

The current study at the Boston VAMC's Women's Health Science Division on the effects of PTSD on women veterans' mental health and physical well-being appears to be a serious step in the right direction. The study aims at improving the assessment and treatment of PTSD in women veterans. In addition, it will train the medical staff in PTSD. Sadly, many VAMCs still need such training. We see this as an important function of the Rockefeller draft bill.

VVA supports increasing access for all war-time veterans to appropriate care within the VA by expanding and improving current specialized PTSD treatment units, and by providing additional research into modalities of treatment. It has been

suggested that the expertise of the National Institutes of Mental Health and the Center for Mental Health Services be integrated. Furthermore, the Rockefeller draft bill could encourage health professional specialization in PTSD under the VA Health Professionals Scholarship Program and allow VA provision of counseling services to veterans' families through the Vet Center program.

Inpatient PTSD units operated by the VA, of which there are only 20 system-wide at present, must be increased by another 30 such units within the next four years. In addition to this, so as to assure proper treatment of PTSD in VA facilities lacking inpatient PTSD units or nearby Vet Centers, the number of PTSD clinical teams (PCTs) should be increased by 50 over four years; there are currently only 57 PCTs. This again is consistent with a new mission for the VA in national health, which we suggested in our April 27 testimony.

In addition to the increase in Specialized Inpatient PTSD Units (SIPUs) by 30 units over the next four years, Congress should provide authorization for an additional number of the smaller inpatient units that VA has designed to provide care for those awaiting openings in SIPUs (Evaluation and Brief Treatment Units; currently, there are 8-9 units) and post-SIPU adjustment (Residential Rehabilitation program; currently there are 10 units). The number of these units should be tripled with incremental steps stipulated over the same four year period.

Finally, the importance of creating statutory authorization for the Advisory Committee on Readjustment of Veterans has become vital just this year. The Committee is a viable sounding board for consumer recommendations on the VA PTSD and readjustment programs. As a result of President Clinton's recent Executive Order terminating all non-statutory advisory committees, this program is on the chopping block, and needs to be preserved.

Chronic PTSD is widespread and has associated disorders such as depression and substance abuse. Dual-diagnosis also complicates the treatment process. Awareness needs to be raised throughout the Veterans Health Administration of the symptoms and proper modalities of treatment for PTSD. Ranging levels of treatment are necessary to provide a continuum of care for individual veterans at varying levels of recovery. These program levels are and should continue to be mutually supportive, so that care and counseling are provided at whatever level is appropriate and accessible.

VVA recommends that the Committee examine whether language ought to be added to the Rockefeller draft bill making the expansions for inpatient care that we have just recommended. Our question is not whether such expansions are needed, for there is no doubt of that, but whether they ought to go into this bill or another one.

ALTERNATIVES TO LONG-TERM CARE OF CHRONICALLY MENTALLY ILL VETERANS

The best alternatives to long-term care for the various forms of chronic mental illness related to PTSD and other major mental illnesses are early treatment and outpatient care. For many 100% mentally-disabled veterans, full-time institutionalization is neither necessary nor desirable. Although some patients may never be released, others are in and out of VA facilities, going in when the stress of their daily lives compounds their problems, and, in intervals, living fairly normal lives after periods of treatment.

The Vet Center program, operated under the aegis of VA's Readjustment Counseling Service (RCS), has done remarkably successful work over time to keep veterans out of long-term institutional care for PTSD. A model of user-friendliness, the Vet Centers have provided individual and group counseling that have given tens of thousands of veterans treatment that has eased their problems before they needed inpatient care.

The need for the Vet Centers has increased since the war in the Persian Gulf. A 1992 Walter Reed Army Institute of Research study shows that 27% of the cases involve seeing dead bodies, and 15% derive from fears of Scud missile attacks. What is important about these stressors is that they do not apply only to "front-line" troops. The potential for a massive influx of Desert Shield/Desert Storm veterans with PTSD is serious. Early treatment through the Vet Centers can keep most of those cases from becoming serious.

THE READJUSTMENT COUNSELING SERVICE AMENDMENTS OF 1993

What early treatment of PTSD will require is both an expansion of the Vet Center program and a recognition by Congress and the VA that RCS is not a temporary administrative structure. We strongly support S. 1226, the Readjustment Counseling Service Amendments of 1993, which will accomplish the second of these aims. It is time to go beyond the biennial rallies to save the Vet Centers, and to recognize

that the alternative is an epidemic of chronic mental disorders stemming from PTSD that will give not only the VA budget but the rest of the nation's social services a frightening burden.

We also understand that 1993 is not a year in which program expansion will be debated on merits rather than on costs. That is unfortunate, because there is a real need for more Vet Centers, and such an investment would keep many veterans from needing long-term care in the next few years, which would give this nation a savings in both dollars and misery. The one weakness in S. 1226 is that a needed expansion of Vets Centers is absent from it. Economizing on preventive medicine is a false economy, and we will all regret it.

If need and prudence alone were not sufficient reason to expand the Vet Centers, looking forward to a new mission in mental health care for the VA under national health care reform adds another. As so many veterans have warned, unless the VA makes serious changes in both mission and performance, it can expect to suffer a major outflow of its now-captive customers once the programs now on the drawing boards offer veterans a choice.

Mental health care, for the most part, is one of VA's strengths, and one worthy of expansion. With the advent of market considerations in who goes where for treatment, the Vet Centers are a brand name known nationwide for "Help Without Hassles," which has never been the motto of the bulk of the VA. If VA is to survive free choice, it must lead from strength by expanding its best services.

HONEST VA COMPENSATION AS AN ALTERNATIVE TO LONG-TERM CARE OF MENTALLY ILL VETERANS

Although it may not be immediately apparent, there is one other clear and obvious alternative to long-term care of chronically mentally ill veterans: compensation. VVA has again and again described the ongoing need to correct the Veterans Benefits Administration's bias against claims for compensation of PTSD, which results in much higher utilization of long-term care than is necessary.

VBA's regional offices take longer than ever to process claims of all sorts, and especially claims for PTSD and other mental health disorders, which make up a significant portion of the 600,000 case backlog at the Board of Veterans Appeals (BVA). Claims are badly prepared, denied, appealed, ineptly defended against, remanded, recycled and drawn out needlessly in the vain hope that the needy veteran will get tired and go away. Wrongfully withholding money from a veteran with a mental health problem is shameful.

PTSD-disabled veterans whose disability compensation is lower than it ought to be are subjected to a variety of current-day stresses that exacerbate their conditions. These include feelings of anger and injustice, anguish over how real their unrecognized symptoms are, and—most important—stresses around finding work that will support them. No blinded or legless veteran rated 100 percent disabled is required to be unemployable to receive compensation, but the effect of denying such a rating to PTSD-disabled veterans where merited means that their disabilities are ignored by VA in the workplace.

The VA's refusal to rate disabilities for PTSD at comparable levels to physical injuries seems a last vestige of the infamous incident of General George S. Patton slapping a soldier with fatigue-induced tears during a visit in which the visionary commander himself wept at the physical injuries of his other soldiers. This bias for visible disabilities is a vestige of the military's age-old assumption that any health problem that cannot be seen is malingering. It has no place in modern medicine, nor in honoring the losses of America's warriors, especially in the light of the NVVRS finding that for every two soldiers in Vietnam who suffered physical wounds, three were subject to clinical level PTSD.

Nowhere did more offensive evidence of this VA ratings bias show up than in the recent testimony before two House subcommittees on health problems and claims problems of Persian Gulf War veterans. As witness after witness related stories of the VA not only denying that their physical ailments were service-related, but that they were being given 10–20 percent ratings for PTSD, a clear pattern emerged. Any other PTSD claim demands evidence of the traumatic stress from which PTSD springs, stress that was absent in many of these cases. Assessing low levels of PTSD without proof establishes in their files a presumption that these younger veterans are unbalanced complainers. This pattern makes it clear that segments of the VA still consider PTSD bogus.

Minimizing these biases and fairly compensating these veterans is the best guarantee against having to provide long-term care to veterans who could be rehabilitated. VA's hostile, tough-guy, pinch-penny ratings for PTSD save nickels and cost millions of dollars at best, or save nickels and waste lives at worst.

A BLUE-RIBBON PANEL ON THE VA AND PTSD

VVA would like to see a blue-ribbon panel created to take a deeper look at how VA handles—and should handle—cases of PTSD. Such a panel needs to cross VA's administrative boundaries, and find the failed connections between the Veterans Health Administration and the Veterans Benefits Administration with regard to PTSD. Why do so many PTSD-disabled veterans qualify for so much in-patient care and such low compensation ratings? Why does Vocational Rehabilitation pay them so little attention, when so many of them can hold decent jobs? Why, when a PTSD-disabled veteran recovers sufficiently to be given a lower compensation rating, doesn't the VA automatically contact that veteran to provide help in finding work that will make up for the resulting income loss?

Chronic mental illness—whether from PTSD or any other condition—must be recognized as chronic, as an affliction whose effects may ebb and flow without going away. A patient need not be in constant crisis to merit a high disability rating. Tunnel vision in the VA's quickness to downgrade benefits is never matched by its speed in upgrading them, and that demonstrates a bias that does not have the veteran at heart. This bias is too expensive in human lives and taxpayer dollars to condone. We owe both physical and mental injuries the same deep respect, the same competent care and the same fairness in adjudications.

Mr. Chairman, this concludes our testimony.



DEPARTMENT OF VETERANS AFFAIRS
Medical and Regional Office Center
White River Junction VT 05009
National Center for PTSD

In Reply Refer To:

September 17, 1993

Senator John D. Rockefeller IV
Chairman
United States Senate
Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Rockefeller:

Here are my answers to the questions stated in your letter of August 5, 1993 as a follow-up to my testimony at the August 3 hearing on VA mental health programs. I have also enclosed two articles on the VICC (Veterans Integration Community Care) program, which I established in 1979, to supplement my answer to Question # 6.

Thank you for inviting me to participate in this hearing. I appreciate your knowledge and concern regarding the mental health problems of veterans and the challenges facing psychiatry in the VA and nationwide.

Sincerely,

A handwritten signature in cursive script, reading "Matt J. Friedman".

Matthew J. Friedman, M.D., Ph.D.
Executive Director
National Center for Post Traumatic Stress Disorder

enclosures

Response to Questions Submitted by Senator Rockefeller on
Follow-Up to the August 3, 1993
Oversight and Legislative Hearing on
the Department of Veterans Affairs Mental Health Program

1. Are psychiatric treatment regimens any less proven than similarly priced medical or surgical treatments? There are a number of psychiatric treatments that are very well established and which have passed the test of controlled clinical outcome trials. These include drug treatments for depression, bipolar affective disorder, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, and schizophrenia. (Recent pharmacological breakthroughs suggest that we have developed even more effective drugs for depression and schizophrenia.) The efficacy of cognitive behavioral treatments for depression, obsessive compulsive disorder, panic disorder, generalized anxiety disorder, and eating disorders is also very well established. It should be noted that the best treatment for depression is electroconvulsive therapy (ECT) where the success rate is 85-90%. In addition there is a growing literature on effective treatment approaches for alcoholism, substance abuse disorders, post-traumatic stress disorder, and psychiatric treatments for complex patients with two or more psychiatric disorders (dual diagnosis patients). Finally, case manager approaches for schizophrenia and other chronic mental illnesses have been shown to prevent hospitalization, reduce costs, and maximize social and occupational function.

With regard to comparability between the cost and efficacy of psychiatric versus medical/surgical treatments, there is no question that the response to some of the aforementioned treatments frequently results in complete remission (such as lithium for bipolar disorder, several approaches for panic disorder, drug and behavioral treatment for obsessive-compulsive disorder, and a variety of treatments for depression). Such results stand up well in comparison to treatments for hypertension, diabetes, and cardiovascular disease and are markedly better in comparison to very expensive and frequently ineffective treatments for cancer. In this regard, there is absolutely no justification for a two caste system of medical benefits that favor medical/surgical patients and penalizes mental health patients. The most egregious manifestations of this inequity is the cap on mental health coverage known as maximum lifetime mental health benefits.

Let me illustrate this point by a very common example. I can think of several brilliant and productive young patients of mine who, because of genetic loading, suffer from bipolar disorder. These patients have already required several hospitalizations for psychotic manic episodes or suicidal depressive states. They have responded rapidly and completely to inpatient treatment and have been able to return to highly productive lives as professionals, students, parents, etc., for sustained periods (sometimes lasting many years) in between episodes. At this point in their lives they promise to have very productive, if not brilliant, careers that will be personally rewarding and which will benefit their communities and society. At this point they also stand a very good chance of experiencing future relapses of their episodically severe bipolar disorder. Finally, at this point they have completely used up their lifetime mental health benefits. They have no way of paying for future hospitalizations and therefore, hesitate to seek treatment when they are beginning to slide and need treatment the most. In other words, as a result of these discriminatory reimbursement policies, we are penalizing people with treatable and reversible disorders because their illness is psychiatric rather than medical/surgical. Not only is this unfair, it is also irrational. Affective disorders, schizophrenia, panic disorder, obsessive-compulsive disorder, and most other Axis I psychiatric illness appear to be no less "biological" and no less treatable than diabetes, hypertension, cancer, heart disease, etc. Yet we have developed a public policy codified in various reimbursement formulæ that arbitrarily provides open access to treatment for one group of disorders and sets a lifetime cap on psychiatric disorders. Finally, I am not aware of any data suggesting that treatment of chronic medical illness is more cost-effective than treatment of chronic mental illness.

2A. If the level of services remained the same, what portion of veterans seeking mental health services in the future will VA be able to treat? This is a very complicated question because one cannot assume:

- a] that the number of veterans seeking mental health services will remain constant (since all indications are that it will continue to grow);
- b] that the intensity, complexity, and comorbidity of their mental health problems will remain the same (since other psychiatric and/or medical problems as well as the possibility of Alzheimer's or other dementing illnesses will undoubtedly complicate treatment for the aging veteran population);

c] that the current level of resources will suffice in the future to provide adequate treatment for the veterans who currently receive VA mental health care (since the increased intensity, complexity, and medical/psychiatric comorbidity of mental health problems in the aging veteran population may actually increase the annual mental health cost per patient in the future).

I believe that all of these assumptions are false and that none of them are mutually exclusive. In other words, I believe that in the future more veterans will seek mental health care, that their problems will be more severe and complicated, and that consequently the annual mental health cost per patient will increase. I believe it follows from the argument that if we continue to provide the same kind of mental health care and if the level of services remains the same in the future that something will have to give. Either VA's mental health service capacity will only contain enough resources to treat fewer patients than at present or VA will continue to serve the same number of patients but will be forced to provide less treatment per patient than it does at present.

2B. How can VA increase its ability to effectively treat this growing population? There are several answers to this question. First of all, I believe that more resources must be devoted to mental health care and particularly to treatment of long-term mental illness but also for PTSD, substance abuse disorders, Alzheimer's disease, depression, and anxiety disorders. Whether such resources come from additional Congressional funding of VA mental health programs or from reallocation of existing resources within VA is for others to decide. A second possibility is that a national health care system will create opportunities for VA/other federal/state collaborations that will open up more cost-effective options for veterans with mental health problems. (I strongly believed that more creative and collaborative use of public sector resources will benefit veterans and non-veterans alike and that improved treatment at lower cost can be achieved. Later, see Question #6, I will describe a VA/state partnership that I first developed in Vermont and New Hampshire in 1979 that illustrates this point.) Thirdly, VA must rigorously examine its own spectrum of mental health treatment options, especially with respect to long-term mental health care. There must be careful development, pilot testing, and evaluation of non-institutional and community-based alternatives. As I'm sure you have already heard from Drs. Errera, Lehmann, and Rosenheck, testing of such

alternatives has been ongoing since the mid-1980's with the Region I Mental Health Initiative program that has now metamorphosed into the Intensive Psychiatric Community Care (IPCC) program for patients with chronic mental illness. This has been a very successful and cost-effective option for long-term mental health care. It is also important to consider different community-based and non-institutional treatments for mental health patients who suffer from other problems such as PTSD, alcohol or substance abuse/dependency, Alzheimer's or other dementing illnesses, and affective or anxiety disorders. While I strongly support such initiatives, I must emphasize that it is also important to understand the limitations of such programs. These are alternatives, not substitutes for the intense and sophisticated care only available within the hospital. It is essential that professionals who staff such programs understand the need to aggressively seek hospitalization when the clinical needs of the patient are too severe or complex to be treated adequately in a nontraditional setting.

It is also necessary for VA to maintain its sophisticated hospital-based programs which will continue to be needed (even if reduced in scale) to support such community-based alternatives. To cite an example from my own area of expertise, PTSD, it is instructive to consider the Vet Center program. This is a highly successful program that has provided important front-line counseling for war-zone related adjustment problems including PTSD. I am a very strong advocate of Readjustment Counseling Service and, in fact, established the first Vet Center in the USA in Williston, VT on October 1, 1979. In my opinion, the Vet Centers have become a mainstay of our spectrum of PTSD services within VA but they are not a substitute for the sophisticated inpatient and outpatient treatment options that can only be found within VA hospitals. In fact 75% of VA treatment for PTSD is provided in hospital-based programs, not in Vet Centers as many believe. It is not a question of which treatment is best, Vet Center or VAMC, but which treatment is most appropriate for which patients at what time.

It would be a major error if we dismantle needed hospital-based mental health programs (for schizophrenia, substance abuse, PTSD, etc.) in our enthusiasm to develop less costly community alternatives.

3. Is the extraordinarily heavy workload of VA psychiatrists a major reason for the lack of mental health research in VA? I believe

this is a major reason for the low relative percentage of VA research in mental health in comparison with the percentage of research conducted by professionals from other medical specialties. At affiliated hospitals psychiatric clinical responsibilities are augmented by teaching and other academic responsibilities which place additional restrictions on time available for research. At non-affiliated hospitals, patient-to-staff ratios are so overwhelming that there isn't enough time in the day to carry out needed clinical activities and therefore, time for research is totally out of the question.

Because of this workload, VA psychiatry cannot compete effectively with academic departments to recruit psychiatrists with prove research expertise or with the potential to become productive researchers. Lacking its fair share of the pool of research talent, psychiatry cannot compete on an equal footing with other specialists for a diminishing pot of VA research dollars. It's important to understand that skilled psychiatric researchers can command academic positions that guarantee and safeguard the necessary time and resources needed to establish and maintain their research programs. Therefore, the realities of daily clinical responsibilities not only limit the ability of the VA psychiatrist to submit and carry out mental health research, but limit the likelihood that potential researchers will apply for psychiatric positions at VA hospitals.

A third fact that compounds this problem is the current status of the VA research budget. Reductions in the overall VA research budget creates a situation in which senior researchers with ongoing programs are most likely to receive continual support for ongoing programs. New investigators applying for both the Merit Review and RAG programs compete on an unequal footing with establishes senior investigators in the present climate. Since non-psychiatrist researchers are much better established, commanding 88% of current research funding, mental health researchers will remain poorly positioned to compete for limited research dollars unless funds are earmarked for mental health research or unless VA re-established high priority research categories for mental health research. Such a strategy would help foster research by current VA psychiatrists and would significantly improve recruitment of talented psychiatric researchers.

4. What is the nexus between primary care and mental health care? As we all know, the growing specialization in American

medicine has produced fragmentation of care. Currently the organization of our health care system, reimbursement formuli by third part payers, and fiscal incentives for physicians all reinforce and sustain such fragmentation. At this time, the only medical disciplines that see as their responsibility the care of the whole individual (rather than the treatment of a specific organ or system within the body) are primary care, pediatrics, and psychiatry. Although this is especially true for psychiatrist who work in large multidisciplinary institutions such as VA hospitals, multispecialty clinics, and university settings, it also applies to psychiatrist who have a community-based solo or small partnership practice. Let me give a few observations from my perspective as a psychiatrist who has practiced within the VA system for the past twenty years.

First let me cite a few facts:

- a] chronic medical illness increases the likelihood of psychiatric problems;
- b] psychiatric problems often present with neurologic, gastrointestinal, cardiovascular, gynecological, and other medical complaints such as dizziness, vertigo, headaches, loss of appetite, irritable bowel, diarrhea, palpitations, tachycardia, hypertension, pelvic pain, etc.;
- c] common psychiatric disorders such as depression, panic, PTSD, and other anxiety disorders are often unrecognized when the patient initially seeks treatment from a non-psychiatrist. Failure to recognize a disorder such as depression not only delays effective treatment but often results in a costly and irrelevant diagnostic work-up;
- d] since fully forty percent of veterans treated by VA have psychiatric disorders, VA psychiatrists are in a strategic position to oversee and coordinate the overall treatment of a major segment of VA's clinical caseload;
- e] since the well documented comorbidity of medical and psychiatric problems continues to increase with the aging of the veteran population, the strategic role of the psychiatrist as a primary care physician also continues to grow.

From my perspective, the majority of my veteran patients suffer from several medical/surgical illnesses in addition to their psychiatric problems. With the aging of VA patients (including Vietnam veterans) their medical care is increasingly complex. Patients are often confused and overwhelmed when referred to one specialist after another and often fail to have anyone who can help

them integrate the diagnostic assessment and therapeutic recommendations of their many specialists. For many such patients, I am the only clinician who is consistently available to them. I am the only one who can orchestrate their multispecialty clinical care, who takes the time to sit down and explain (in language they can understand and with diagrams they can take home and refer to) what their various medications are supposed to do. I am also, often the only one in the health care system who reviews the many medications they have been prescribed and who coordinates their various treatments and prevents duplication of effort or overprescribing. Furthermore, since I have an ongoing therapeutic relationship, I can often prevent needless referrals to medical/surgical specialists by diagnosing the psychiatric problem behind the somatic complaints when applicable. Another significant role I often assume is as a case manager who by treating the whole patient rather than a specific organ system is functioning as a primary practitioner among many different specialists. My psychotherapy, in effect, is often to help the patient integrate the recommendations of specialists in the context of his wholeness and integrity as an individual.

5. What important or essential mental health research is not being done because of underfunding? The short answer to this question is research on the etiology of all major psychiatric disorders and the treatments that will improve clinical outcomes. Schizophrenia and Alzheimer's Disease are both brain diseases with dreadful outcomes and which extract a huge toll on individuals, families, and society. Technology is available for understanding the neurobiology of both diseases and there are very promising pharmacological breakthroughs in schizophrenia that should be studied extensively. We also need to invest in health services research to understand effective and less costly alternatives to inpatient treatment that will maximize social and vocational functioning. PTSD is one of the only bona fide service connected disorders, since its etiology is clearly due to traumatic exposure during military service. PTSD is complex neurobiologically, psychologically, and psychophysiologically. Treatment outcome research needs to be carried out regarding pharmacological, cognitive-behavioral, dual diagnosis, and psychodynamic therapeutic approaches for PTSD. Treatment research on alcoholism and other substance abuse disorders is of paramount importance. Early intervention and treatment, especially of alcoholism, will prevent major medical/surgical morbidity and costly medical/surgical interventions subsequently. Early

intervention and treatment of intravenous drug abuse will prevent AIDS and other problems subsequently.

The need for research funding for psychiatric disorders suggests that VA should re-establish high priority research categories for the above psychiatric disorders. This might attract experienced mental health researchers into the VA system who would be able to develop and carry out competitive research programs. Attraction of such individuals would also enhance clinical programs thereby improving psychiatric care for veterans overall.

6. What non-conventional programs can VA develop to provide a full continuum of mental health care? As I mentioned in my answer to Question 2B, VA has developed a number of innovative, community-based alternatives to hospital based treatment. The IPCC (Intensive Psychiatric Community Care) program has been successful with chronic mentally ill patients. Likewise, the HCMI program for homeless chronic mentally ill patients has been very effective. The Vet Center program has significantly improved our capacity to reach and treat war-zone related psychological problems such as PTSD. I'm sure that Dr. O'Brien will describe a number of alternative approaches for alcoholism and substance abuse. The Committee has access to many experts who can describe each of these programs better than I can. Therefore, I'd like to take this opportunity to describe a VA/state partnership that I developed in 1979 that is still going strong.

Veterans Integrated Community Care (VICC) is a mental health delivery model developed for veterans in rural areas that is a partnership between VA and the state community mental health system. VICC mental health clinicians are employed by the VA to provide outpatient treatment for veterans. Instead of working in hospital-based mental hygiene clinics however, they are stationed full-time in Community Mental Health Centers (CMHC) located many miles and many hours from the VAMC. This program made it possible for Vermont and New Hampshire veterans to have greater access to VA mental health services, it made it possible to integrate VICC/VA treatment with CMHC treatment, and it made it possible to integrate VICC/VA treatment with CMHC treatment for other members of veterans' families when appropriate. The American Psychiatric Association's Institute on Hospital and Community Psychiatry conferred its Significant Achievement Award on the VICC program in 1988. Most important, however, is that long-term

treatment outcomes for VICC patients were better than for veterans who received hospital-based outpatient mental health treatment. Furthermore, the costs of VICC treatment were lower than those for hospital-based outpatient treatment. I have attached some articles that describe the VICC program in greater detail and demonstrates the successful treatment outcome data.

I believe VICC is important for two reasons. First of all, it is an innovative treatment approach that works. Although designed for rural areas, I believe it would be equally adaptable in urban settings. Secondly, VICC breaks through bureaucratic barriers within the public sector and shows that VA and the state CMHC system can collaborate smoothly and cost-effectively. Unlike other alternative programs, VICC is not tied to a specific type of patient (schizophrenia, PTSD, substance abuse, etc.) but can be adapted to serve a very wide spectrum of psychiatric problems. It can not only interface effectively with CMHC and VA hospital-based programs but also with other VA community programs. For example, VICC clinicians have worked closely and effectively with Vet Centers in Vermont. VICC clinicians also function as case managers who refer (and later follow) patients who need more intensive or specialized treatment. In my very biased opinion, I believe VICC is a treatment model with great potential that deserves more attention.

cations, Project ACCESS also educates the public about mental health issues through presentations to self-help groups, law enforcement agencies, mental health professionals, private and public agencies, legislators, educational institutions, and neighborhood organizations. Project ACCESS staff have given presentations at local and national conferences, participated in several radio talk shows, and developed a public service announcement.

The collaborative development of Project ACCESS publications

has ensured their widespread relevance and has created greater cooperation among Philadelphia's mental health service agencies. Project ACCESS has not only helped consumers understand and use Philadelphia's mental health service system; its work has also improved the system.

For more information contact Phyllis Ledbetter, Director, Mental Health Association of Southeastern Pennsylvania, 311 South Juniper Street, Philadelphia, Pennsylvania 19107; telephone, 215-733-2465.

Accessible Psychiatric Outpatient Treatment for Veterans—Veterans Integrated Community Care Program, Veterans Administration Medical and Regional Office Center, White River Junction, Vermont

Veterans living in remote parts of Vermont and northern New Hampshire no longer must battle harsh New England winters, an inadequate cross-state road system, and mountainous terrain to obtain psychiatric outpatient services at the Veterans Administration Medical Center in White River Junction. Through an innovative arrangement between the VA and six regional community mental health centers, they can receive the same outpatient services they would have received from the hospital at their local community mental health center.

The VA Hospital in White River Junction serves a large catchment area comprising all of Vermont and five counties in western and northern New Hampshire. A large majority of the area's residents, 85 percent, live in towns of fewer than 10,000, and many are poor. Affiliated with Dartmouth Medical School, the hospital has 224 beds and offers acute medical, surgical, and psychiatric inpatient treatment. It also operates a 16-bed alcoholism rehabilitation program, an ambulatory surgical program, and a 30-bed nursing home unit. The hospital is one

of the state's primary providers of mental health services and at its current pace will have approximately 7,000 psychiatric outpatient visits this year.

Under the program, called Veterans Integrated Community Care, or VICC, the VA takes full responsibility for providing outpatient services for veterans in the CMHCs' catchment area in return for the use of the centers' facilities and staff support. Both the VA and the centers view the program as a fair exchange, according to Matthew Friedman, M.D., Ph.D., chief of the hospital's psychiatry service and the program's originator, and no money changes hands between them.

Master's-level therapists, called VICC clinicians, provide the bulk of outpatient treatment for veterans at the community mental health centers. All of the participating centers except the one in Burlington are assigned one VICC clinician. Two VICC clinicians work in Burlington, where a third of the patients in the VA's catchment area reside. VA psychiatrists work part time in the centers serving Rutland County, Burlington,

and the Northeast Kingdom region, all in Vermont.

The VICC clinicians play an important role in ensuring continuity of care within the VA system. They screen acutely ill veterans and explore all alternatives to inpatient care. If hospitalization of the patient becomes necessary, they provide the VA's inpatient staff with the patient's treatment records and important clinical information, such as details about the patient's family problems. The VICC clinicians also work with the inpatient staff to develop comprehensive treatment goals that can be pursued after the patient's discharge. The clinicians resume therapy with the patients after their discharge and make sure they are referred to the appropriate community support services.

Although they are supervised by the hospital-based project director, the VICC clinicians are considered members of the CMHC staff. They participate in the center's on-call-duty rotation, provide VA benefits counseling to the center's patients, and make regular referrals to other CMHC programs, such as those providing transitional care, day treatment, and alcohol and substance abuse treatment. The centers and the VA share responsibility for recruiting the VICC clinicians.

Project director Lorraine E. Peirce, R.N., M.A., plays a key role in ensuring that the program runs smoothly, said Dr. Friedman. Ms. Peirce meets with each VICC clinician at least three times a month, twice at a CMHC and once at the hospital in White River Junction. During her visits to the centers, she provides the VICC clinicians with clinical and administrative supervision and reviews the clinicians' performance with their supervisors at the centers. She facilitates good communication between the VICC clinicians and the inpatient staff.

The VICC program was proved effective in pilot testing conducted between 1978 and 1981 at two

Vermont CMHCs. A follow-up study comparing outcomes of veterans served in the VICC with those served at the VA hospital indicated that while both groups improved, only the VICC-treated veterans maintained their improvement over the nearly four-year follow-up period. Treatment through the VICC program was also substantially less expensive, costing \$14 to \$20 a visit compared with \$32 to \$38 a visit for hospital-based outpatient care. These results, as well as increased interest by the VA in developing alternative and innovative treatment strategies, contributed to the renewal of the program in 1987, said Dr. Friedman, who led the

team that conducted the follow-up research.

The program has helped the VA overcome its long isolation from the rest of Vermont's mental health community, Dr. Friedman said. That's good for the VA, he believes, and especially good for the many veterans who are now minutes, not hours, away from a dependable source of outpatient mental health treatment.

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Assertive At-Home Case Management for Impaired Elderly Persons—Elderly Services Program, Spokane (Wash.) Community Mental Health Center

Many highly dysfunctional elderly residents of Spokane, Washington, continue to lead productive lives in the community thanks to the comprehensive care provided by the Elderly Services Program of the Spokane Community Mental Health Center. Ray Raschko, M.S.W., is director of the program, which has been in operation since 1978. Mary Higgins is executive director of the community mental health center.

The program has two main components—at-home services providing evaluation, treatment planning, and aggressive case management for very impaired and socially isolated elderly individuals and 24-hour telephone information and referral for higher-functioning elderly persons and those with more adequate social support systems. In addition, it conducts aggressive outreach through an extensive network of community "gatekeepers."

Each individual enrolled in the at-home case management program, coordinated by Francie Coleman, is assigned to a multidisciplinary team. Five of the teams are staffed by three case managers and

a trained geriatric mental health specialist, usually a nurse, who serves as team leader. A sixth team is staffed by three social work students from the School of Social Work at Eastern Washington University and is led by their practicum supervisor, also a social worker.

Treatment plans are drawn up by a case manager and the team leader, who are responsible for ensuring that the elderly patients receive any and all services they need to maintain their independence and avoid premature or unnecessary institutionalization. Some of the services most commonly required by the elderly patients are nursing care, legal assistance, meal delivery, help in obtaining Medicaid or food stamps, and assistance with housekeeping, food preparation, and home repairs. The services are provided through contracts with 14 local agencies, most of which are funded by the Eastern Washington Area Agency on Aging, which provides 60 percent of the program's funds. (The Washington State Mental Health grant-in-aid program and the National

Institute on Drug Abuse provide the rest.)

A staff psychiatrist, who works in the program 35 hours a week, and family medicine residents from the University of Washington provide the elderly participants regular in-home evaluation and treatment. The case managers continue to make regular visits to the elderly participants for as long as they remain in the program. Treatment plans are reviewed every 30 to 90 days by the case manager and the team leader in charge of the case.

Staff of agencies that provide contractual services receive 20 hours of training from the elderly services program about dementia, depression, mental status, and medications. They are asked to report to the program any decline in the elderly participants' functioning and are expected to attend weekly case conferences. A special group of 25 higher-paid agency staff receive additional training in working with behaviorally disturbed elderly persons and are assigned to the homes of those who are at the greatest risk of institutionalization.

One of the most innovative aspects of the program is its reliance on a network of community residents, or "gatekeepers," to identify elderly individuals who require mental health and medical interventions. Gatekeepers are individuals who come into regular contact with the elderly, usually through their work. They include gas and electric company repair workers, postmen, managers of apartments and mobile home communities, pharmacists, fuel oil distributors, grocery store employees, water meter readers, and police and fire fighters. Referrals by gatekeepers account for four of every ten admissions to the case management program, according to Mr. Raschko.

In 1987 the Elderly Services Program provided at-home services to 636 elderly individuals with serious economic and health problems. Sixty-two percent of the par-

Integration of VA and CMHC Care: Utilization and Long-Term Outcome

Matthew J. Friedman,
M.D., Ph.D.
Alan N. West, Ph.D.
Austen Clark, D.Phil.

An innovative treatment program was established through which VA outpatient mental health care was decentralized via integration with the CMHC system in northern Vermont. A long-term follow-up study evaluated the success of Veterans' Integrated Community Care (VICC) in meeting its goal of enhanced access to care and better treatment outcomes. Three groups were compared: veterans who were transferred from VA hospital care to VICC care, veterans who were treated at the VA hospital only, and veterans who were newly reached through the VICC program. Follow-ups were conducted 18 months after intake and at least two years thereafter. Results indicate that all groups were improved symptomatically at the first follow-up, but only VICC patients maintained this improvement subsequently. By the last follow-up, VICC patients had reduced their utilization of VA psychiatric care, whereas veterans who had received only hospital-based care had not. VICC

treatment represents a viable alternative to centralized VA mental health care.

Decentralization of mental health care began with the Community Mental Health Centers Act of 1963 (P.L. 88-164, Title 2). This legislation aimed to increase public access to treatment; traditionally public psychiatric care was provided on a centralized, regional basis. With the CMHC movement, mental health services were dispersed into multiple catchment areas, thereby enhancing the availability of care for the underserved.

Predictably, greater access to care led to dramatically increased utilization of mental health services (1-4). Use of catchment areas also induced the development of innovative treatment approaches to meet the increased demand for services. Brief psychiatric hospitalizations (5-7) became more commonplace as aftercare and alternative programs emphasizing family involvement, social and vocational skills training, community-based residential care, and day hospital treatment were introduced (8-18). Alternative outpatient treatment programs have substantially reduced the utilization of inpatient psychiatric services (16-18).

The shift from hospital to community-based treatment during the past 30 years was spearheaded by politicians rather than by the professional community. Planning for the community mental health movement was based on very limited scientific data (19,20). Moreover, the evidence available today is still inefficient for evaluating the efficacy of community-based care. According to Langsley (20), most reports have provided simple "head counts" of state hospital alumni reregistered in community programs rather than evaluations of clinical outcomes. Mollica (21) concluded that "outcome studies on public programs do not exist."

Hence much remains to be learned about the efficacy of community-based care relative to traditional, centralized services. We were fortunate to have a unique opportunity to study this issue within the context of the Veterans Administration's system of care. Currently the VA continues to deliver its mental health services on a centralized basis. The VA at large has neither adopted the community-based service delivery model nor made structural changes such as decentralizing outpatient services. Although VA mental health care is provided free of charge to veterans, its centralized delivery mode often precludes ready accessibility. Within this context, we developed and evaluated the efficacy of an experimental program of decentralized mental health care for veterans.

The treatment program was implemented and administered by the Veterans Administration Hospital in White River Junction, Vermont. The catchment area served by this hospital comprises all of

Dr. Friedman is chief of psychiatry and Dr. West is acting director of outpatient psychiatry at the Veterans Administration Medical Center in White River Junction, Vermont. Dr. Friedman is also associate professor in the department of psychiatry and associate professor in the department of pharmacology at Dartmouth Medical School in Hanover, New Hampshire; Dr.

West is research assistant professor in the department of psychiatry there. Dr. Clark is associate professor in the department of philosophy at the University of Tulsa. Dr. Friedman's address is VA Medical Center, White River Junction, Vermont 05001. This research was supported by a health services research and development grant from the Veterans Administration.

Vermont and five counties of western and northern New Hampshire. The area is primarily rural (85 percent of the people live in towns of fewer than 10,000), the population is predominantly Caucasian, and poverty is common. Considerable social and cultural encapsulation exists; for example, adolescent runaways rarely travel more than 50 miles away.

Because of mountainous terrain, harsh winter conditions, and lack of a convenient east-west highway system, it is often difficult for veterans to travel the long distances to and from the VA hospital. Moreover, the hospital's centralized care generally does not provide for family treatment, does not permit intensive aftercare and follow-up, and is often costly to veterans in terms of lost work time.

Between October 1, 1979, and December 31, 1981, the hospital administered its innovative program of decentralized mental health care delivery. The program aimed to enhance access to VA mental health care through the integration of services with the Vermont community mental health center system. VA psychiatric social workers were assigned to work at selected community mental health centers with the mandate to provide psychotherapy and to expedite and coordinate the treatment needs of veterans residing in the CMHC catchment area. This treatment program was known as VICC—Veterans' Integrated Community Care.

The VICC treatment program was evaluated by assessing utilization and long-term treatment outcomes. Participants in the program were compared with veterans who continued to receive outpatient treatment at the VA hospital. A broad range of outcome measures were considered, including psychiatric symptomatology, therapeutic goal attainment, employment status, substance abuse, and level of involvement with family or friends. This report describes the program's efficacy in terms of relative changes from baseline functional levels as well as the relative permanence of these changes. In

addition, it addresses the program's impact on the utilization of health care services.

It should be emphasized that the VA outpatient population differs from the populations usually studied in the deinstitutionalization-decentralization literature. On the one hand, although the VA treats many chronic, permanently disabled psychiatric patients, its outpatient psychiatric population is generally healthier and more diverse than the chronic deinstitutionalized state hospital alumni who have served as subjects for many studies. On the other hand, the chronicity and morbidity of the VA population are far greater than for the population at large, which has been investigated in community or catchment area studies.

In summary, several hypotheses were inherent in the program. We hypothesized that the VA system could be meshed with the community mental health system to permit VA mental health professionals to operate full-time at CMHC sites. We assumed that by enhancing access to VA-sponsored care in this manner, we could alter veterans' utilization patterns and reduce the long-term consumption of hospital-based care. And we predicted that the greater accessibility of decentralized and integrated mental health services would improve the veterans' outcome.

Method

The program

VICC services were established in two community mental health center catchment areas in northern Vermont. Two other catchment areas (one in Vermont, one in New Hampshire) served as control areas. Control areas were selected to match the experimental areas demographically and geographically in terms of distance from the VA hospital. Throughout the study, veterans who resided in the control areas received VA mental health care at the hospital only. Veterans from the experimental areas could opt to be treated at the VA hospital, receive VICC services at the local community mental health center, or do both.

Two VA psychiatric social workers, known as VICC clinicians, were placed in each of the community mental health centers in the experimental areas. They functioned as regular members of the treatment staff except that they treated only veterans of military service. The clinicians participated in clinical supervision, case conferences, and peer review functions, as did non-VA members of the CMHC staff. They were recruited by VA hospital and CMHC staff jointly and were expected to meet both VA and CMHC performance standards.

Services provided by VICC clinicians included psychotherapy, aftercare, liaison to the VA hospital, and sharing of responsibilities and on-call duties with other CMHC staff. VICC clinicians were the primary therapists for veterans, and they provided support to veterans' families by referring them to other services available through the community mental health center. After exploring community alternatives exhaustively, VICC clinicians screened veterans for hospitalization at the VA hospital. They facilitated continuity of care with the hospital by providing inpatient staff with CMHC treatment records, information about family, and other data relevant to treatment planning, and they collaborated in the development of long-term treatment goals.

VICC clinicians also provided aftercare services, including therapy and referrals to community support services, to veterans who were discharged from VA psychiatric hospitalization. The clinicians provided counsel on VA benefits and referred their clientele to other programs at the community mental health center (such as transitional care, day treatment, and alcohol and substance abuse treatment) as indicated.

The community mental health centers provided office space, secretarial and administrative support, clinical supervision, and clinical support for the VICC clinicians. In exchange, the clinicians participated in the centers' emergency and on-call rotations.

Program evaluation

Three subject groups were identified for comparison. "Transfers" included veterans from experimental areas who had been receiving psychiatric care at the VA hospital and chose to transfer to the VICC clinicians. "Community controls" included veterans from experimental areas who had not been in outpatient psychotherapy during the preceding year and whose point of entry to the VICC program was the community mental health center rather than the VA hospital. "VA controls" were veterans from control areas who received VA mental health care at the VA hospital only. There were a total of 94 transfers, 116 community controls, and 116 VA controls.

Each subject underwent a series of structured interviews administered by a trained, bachelor's-level interviewer. Interviews were conducted when the subject entered the study, 18 months after entry, and approximately two years after the 18-month follow-up. The initial interview assessed numerous background variables, including demographics such as age, education, annual income, employment status, marital status, and household composition, and past utilization of a variety of VA and non-VA mental health services. Recent psychosocial stressors were measured by Holmes and Rahe's Social Readjustment Rating Scale (SRRS) (22), and baseline functional levels on several outcome measures were assessed, including the Symptom Checklist 90 (SCL-90) (23), a self-report measure of psychiatric symptomatology; a questionnaire assessing frequency of alcohol and drug abuse during the previous month; and two indexes of social participation—the Family Involvement and Involvement With Friends Scales (standardizations are reported by Clark and Friedman (24)).

The 18-month follow-up assessment involved all of the outcome measures listed above as well as the Goal Attainment Scale (25), which reflects a client's rating of progress toward therapeutic goals established at intake. Utilization of

Table 1
Group characteristics of transfers, VA controls, and community controls at intake

Variable	Transfers (N=94)		VA controls (N=116)		Community controls (N=116)	
	Mean	SD	Mean	SD	Mean	SD
Age	43.0	12.7	49.0*	12.6	40.1	12.7
Education (years)	11.7	2.6	11.5	2.9	12.2	2.5
Annual income (thousands of dollars)	10.1	6.1	10.9	9.4	10.3	6.9
Weeks unemployed in previous year	27.5	22.5	35.5*	21.3	22.1	21.4
Dependents	3.0	1.8	2.7	1.6	3.2	1.9
Persons in household	2.8	1.6	2.7	1.6	3.0	1.9
SRRS score	100.7	74.8	82.4**	72.6	110.4	72.8

*VA controls differed significantly from transfers and community controls at $p < .001$.

**VA controls differed significantly from community controls at $p < .05$.

mental health services during the 18-month period was assessed via searches of VA and CMHC clinical records.

Of the 94 transfers in the program, 51 completed the 18-month outcome interview. Fifty of the 116 community controls completed the interview, and 93 of the 116 VA controls did so. Comparisons of baseline outcome data for subjects who remained in the study and those who dropped out before the 18-month interview revealed no significant differences. Since our outcome findings were not distorted by the attrition of subjects, we confined all subsequent analyses to subjects who were followed for the full 18 months of the program.

The final interview reassessed outcomes and utilization of mental health care an average (\pm SD) of 27.8 months \pm 4.5 after the 18-month interview (the range was 17.3 to 35.8 months). Subjects were asked to estimate their number of visits to local community mental health centers, including former VICC treatment sites, and any other non-VA facilities during the interval between the 18-month and the final interview. The final interview was completed by 49 transfers, 43 community controls, and 66 VA controls. Again, within each group initial values on outcome measures were not significantly different for those who were lost to follow-up between the 18-

month assessment and this final assessment and those who were followed to the final interview.

Results

The groups were compared on each variable assessed at the initial interview. Table 1 shows group means and standard deviations for selected demographic variables and the SRRS. In general, the groups were comparable demographically. However, compared with veterans who received community care (the transfers and the community controls), veterans who received care at the hospital (the VA controls) were older and had worked less during the previous year. The VA controls' scores on the SRRS were significantly lower than those of the community controls, indicating that VA controls had experienced fewer stressful events.

Community controls, on the other hand, were more likely to be working at intake ($\chi^2 = 11.34$, $df = 2$, $p < .01$). Close to 54 percent of the community controls were working at intake, compared with 37 percent of the transfers and 27 percent of the VA controls.

The groups did not differ significantly at intake on the SCL-90, the Family Involvement or Involvement With Friends Scales, average monthly consumption of alcohol or frequency of drinking, and frequency of drug abuse. These measures indicated that the subjects

were impaired symptomatically and interpersonally and tended to abuse alcohol but not other drugs.

Service utilization

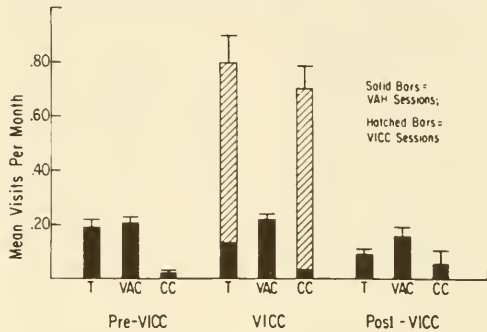
Figure 1 shows each group's average monthly utilization (and the standard error) of VA-sponsored outpatient mental health care both at the VA and in the community during three time intervals: the 18 months preceding the community care program, the 18 months of the program, and the two years afterward. Groups differed significantly in their consumption of VA hospital-based care before the program ($F=24.27$, $df=2,322$, $p<.001$); Scheffé's test revealed that community controls attended fewer sessions at the VA hospital than did the other groups. During the program, community controls attended fewer sessions at the VA hospital than did the transfers, who in turn attended fewer than did the VA hospital controls ($F=25.25$, $df=2,274$, $p<.001$). As the figure shows, utilization of community care was much higher than utilization of VA hospital-based care. During the post-VICC period, groups did not differ significantly in their utilization of VA hospital outpatient psychiatric care.

To determine whether access to the community-based treatment program reduced subsequent utilization of centralized VA hospital care, we compared each group's monthly use of hospital care during the 18 months preceding the VICC program with its monthly use of hospital care after the program ended. Transfers showed a significant reduction in their use of VA hospital care after the program ($t=3.31$, $df=40$, $p<.01$), whereas the control groups showed no significant change. Access to VICC care reduced the transfers' subsequent utilization of VA hospital psychiatric care, whereas VA controls' utilization of VA care remained fairly constant throughout the study. For community controls, access to community care did not increase consumption of VA hospital psychiatric care later.

The VICC program arose from an assumption that rural veterans

Figure 1

Mean monthly outpatient visits to VA hospital and Veterans' Integrated Community Care sites by transfers (T), VA controls (VAC), and community controls (CC) before, during, and after the VICC program



T-shaped line indicates standard error.

need and want mental health care closer to their own communities. To test this assumption, we examined the number of sessions the three groups attended at non-VA hospital and non-VICC mental health care sites during the 18 months of the community care program. As expected, VA controls (who were not eligible for VICC services) used more of these alternative services than did the transfers or the community controls ($F=8.75$, $df=2,321$, $p<.001$).

VA controls who used alternative services during the VICC program, compared with VA controls who did not, attended fewer outpatient psychiatric sessions at the VA hospital during the 18 months preceding the program ($t=3.58$, $df=111$, $p<.001$). They also attended fewer outpatient sessions at the VA hospital during the program ($t=2.02$, $df=112$, $p<.05$). However, they reported more symptomatology on the SCL-90 at the initial interview than did VA controls who did not use alternative services ($t=2.34$, $df=111$, $p<.05$). In other words, VA controls who were most symptomatically distressed at intake tended to

rely on community-based rather than VA hospital care.

The differences found among the groups in alternative services used during the VICC program were not found at the final assessment. The three groups did not differ significantly in their number of visits to local community mental health centers or to other non-VA mental health services during the approximately two years after the program ended. This may reflect the fact that all groups reported lower utilization of alternative mental health resources during this period.

Outcome measures

The SCL-90. The groups' scores on the SCL-90 did not differ significantly at intake. Figure 2 shows the mean changes (plus standard errors) in the scores from the initial interview to the 18-month follow-up and from the initial interview to the post-VICC follow-up. Changes in symptomatology were assessed via repeated measures analysis of variance, with treatment group as a between-subjects factor and interview as a within-subjects factor.

An analysis of changes from in-

take to 18-month follow-up revealed a significant main effect for interview, which indicated general reduction in symptomatology across groups ($F=10.53$, $df=1,187$, $p<.001$). There were no significant differences between groups. Analysis of baseline scores and post-VICC follow-up scores also yielded a significant main effect for interview ($F=8.79$, $df=1,150$, $p<.01$) as well as a significant interaction of group with interview ($F=4.51$, $df=2,150$, $p<.05$). As Figure 2 shows, those who participated in the community care program (the transfers and community controls) maintained longer term improvement in symptomatology, whereas those who did not (the VA controls) returned to baseline levels.

Other measures. The groups did not differ significantly at intake on the Family Involvement or Involvement With Friends Scales, average monthly consumption of alcohol or frequency of drinking, or frequency of drug abuse. In addition, they showed few significant differences on such measures at either the 18-month or the post-VICC follow-up. The groups did not differ with respect to their achievement of therapeutic goals (the GAS) or to changes in em-

ployment rate, family involvement, frequency of illicit drug use, or frequency of alcohol use. Average monthly consumption of alcohol did decrease across groups from 26 ounces at intake to 18 ounces at the final follow-up ($F=3.91$, $df=1,199$, $p<.05$).

The groups did show some differences, however, in their involvement with friends. Although this measure was unchanged at the 18-month follow-up, the main effect was significant at the posttreatment interview ($F=4.35$, $df=1,188$, $p<.05$). An interaction of interview with group indicated that transfers' involvement with friends improved substantially and community controls' involvement improved somewhat, whereas VA controls' involvement declined slightly ($F=4.00$, $df=2,188$, $p<.05$).

In summary, transfers showed significant improvement in SCL-90 symptomatology at the 18-month interview and even greater improvement two years later at the post-VICC follow-up. They also reported greater involvement with friends at the final follow-up. Community controls also improved on the SCL-90 at 18 months and subsequently. VA controls were improved symptom-

atically at the 18-month interview but returned to their baseline SCL-90 levels at post-VICC follow-up.

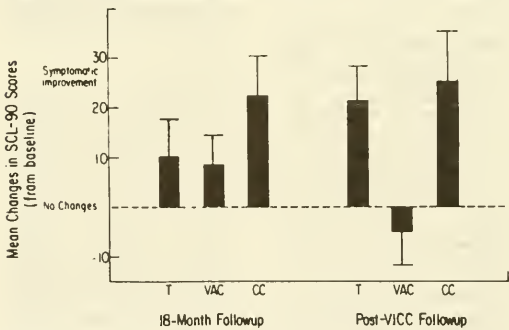
Discussion

Through the Veterans Integrated Community Care program, VA mental health care was provided to rural veterans in or near their own communities. Among psychiatric outpatients who were transferred from VA hospital-based care to VICC care, the impact of this innovative treatment approach on both utilization patterns and outcomes was substantial. Transfers who had been customers at a VA hospital outpatient psychiatric clinic were weaned from that delivery mode and reoriented toward community-based services. VA controls, who were similar to the transfers in their demographic and psychiatric backgrounds, did not show a comparable reduction in utilization of VA hospital psychiatric care. More important, transfers maintained a significant improvement in psychiatric symptomatology for at least two years following VICC treatment, while VA controls relapsed to intake functional levels. Following the VICC program, transfers functioned better and used less VA hospital-based care than the VA controls.

The community controls also showed sustained symptomatic improvement after the community care program ended. They had utilized VICC treatment as extensively as the transfers, but they were not drawn into the VA system to become long-term consumers subsequently. By the end of the study, community controls utilized no more VA hospital psychiatric care than they had before the VICC program began.

Hence the VICC treatment program served dual functions. By improving access to VA therapists, it brought free mental health treatment to a new group of veterans. By providing a transition from the VA hospital to the community, it gradually weaned long-term consumers from VA hospital-based care. In both cases, it demonstrated its long-term effectiveness as a treatment modality. Though all

Figure 2
Mean changes in SCL-90 scores for transfers (T), VA controls (VAC), and community controls (CC) from baseline to 18-month follow-up and from baseline to final follow-up



T-shaped line indicates standard error.

groups improved symptomatically during the life of the program, only patients involved in the VICC program showed sustained improvement at follow-up more than two years later. These findings highlight the necessity of extended follow-up intervals in treatment evaluation studies.

The increased use of alternative services by veterans not receiving community care (the VA controls), and the more severe psychiatric impairment of the VA controls who did use such services, unexpectedly provided additional evidence of the demand for community-based mental health care for veterans. Despite their more severe impairment, these VA controls used less VA outpatient care and chose instead to seek treatment in their home communities. We speculate that they accurately perceived the limitations of VA-based psychiatric care, in that it could not provide sufficient psychotherapeutic contact to meet their needs. We think they would have used VICC care extensively if it had been available to them.

Perhaps the greatest value of our study is that it demonstrates the feasibility of integrating VA mental health services with those of the community mental health center system. Each CMHC had its own organizational principles, logistic problems, treatment philosophy, and clinical priorities so that each site posed a unique challenge in establishing VA-sponsored community care. Yet with good will on all sides, careful negotiations, and continued monitoring, many initial difficulties were overcome, and an effective and smoothly functioning system was established in which VA mental health professionals were fully integrated with the staffs of two different centers.

No money changed hands for the reciprocal relationship developed between VA clinicians and CMHC staff. The community mental health centers provided facilities and staff support in exchange for clinical services. Subsequent cost-accounting indicated that the arrangement was a fair exchange. Another benefit to the

centers was that veterans represented index cases through which family members might be referred for treatment. For all these reasons, we believe that the VICC treatment approach represents a viable alternative to centralized VA mental health care.

The Veterans Administration has recently funded an expanded VICC program as a three-year demonstration project in which decentralized and integrated care will be provided through collaboration with six community mental health centers in Vermont and New Hampshire. The same outcome instruments will be used to continue evaluation of this service delivery approach.

Acknowledgments

The authors thank Roger Strauss, Ph.D., and his staff at Washington County Mental Health Services as well as George Coulter and his staff at Northeast Kingdom Mental Health Services for their support and collaboration on this project.

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QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER TO
THE HONORABLE HERSHEL GOBER,
DEPUTY SECRETARY OF VETERANS AFFAIRS
IN FOLLOWUP TO THE AUGUST 3, 1993,
OVERSIGHT AND LEGISLATIVE HEARING ON
THE DEPARTMENT OF VETERANS AFFAIRS' MENTAL HEALTH PROGRAMS

1. The Committee has been told that 40 percent of VA's patients receive psychiatric care, yet only 12 percent of VA's research budget is spent on mental health research. In light of the fact that VA research is cost effective and beneficial to veterans, why isn't VA doing more?
2. The Committee is aware that VHA may be implementing Resource Planning and Management (RPM) this Fall. Please review the funding for mental health services under RPM and describe the relationship between the two.
3. Please provide the Committee with the total amount of money spent by the Department of Veterans Affairs for service-connected disability benefits for mentally ill veterans. Please provide this information for FY 1991, 1992, 1993 (est.), 1994 (est.), and 1995 (est.).
4. Please provide the Committee with the total amount of money and number of research projects funded during FY 1992 and FY 1993. Further, please provide the total number of VA research projects and the total amount of money spent on mental illness research.

**QUESTIONS SUBMITTED BY HONORABLE JOHN D. ROCKEFELLER IV
SENATE COMMITTEE ON VETERANS' AFFAIRS
IN FOLLOW-UP TO THE AUGUST 3, 1993
OVERSIGHT AND LEGISLATIVE HEARING ON
THE DEPARTMENT OF VETERANS AFFAIRS' MENTAL HEALTH
PROGRAMS**

Question 1: The Committee has been told that 40 percent of VA's patients receive psychiatric care, yet only 12 percent of VA's research budget is spent on mental health research. In light of the fact that VA research is cost effective and beneficial to veterans, why isn't VA doing more?

Answer: The Research and Development Program recognizes the need to do more in the area of mental health/mental illness. Indeed, many past appropriation requests, as well as the current request, specifically indicate the desirability of strengthening research in this area. Further, a symposium is being planned, in conjunction with the National Foundation for Brain Research, for November 1993 to deal with "the future of VA mental health research." This symposium will include participation by congressional members and staff. One of the goals of this symposium is to promote and stimulate interest in research in mental illness in VA.

Having acknowledged that more research needs to be done in the mental health area in the future, we also note that this area is by no means being neglected. Because the bulk of VA's research funding is for investigator-initiated research, it makes sense to examine how well proposals in the mental health are fare in comparison to proposals submitted in other areas. The mean priority score (25.4) for mental health proposals reviewed from 1983 through 1992 was the lowest (most favorable) for all of the 14 merit review boards (formed to evaluate proposals in various disease/topic categories). The number of awards made from 1982 through 1992 for mental health and behavioral sciences research was second only to neurobiology.

HONORABLE JOHN D. ROCKEFELLER IV

We believe that the figures given to the Committee, while accurate, require some interpretation. There are several possible statistics that can be used to describe the magnitude of mental illness among veterans, and the 40 percent cited in the question gives a higher estimate than some others. For example, it is estimated that 14 percent of all veterans have a form of mental illness. Because of the large number of veterans with mental illness using VA long-term facilities, psychiatric inpatients account for about 33 percent of all VA inpatients at any given time. Because of a high recidivism rate, psychiatric patients account for about 43 percent of total inpatient days of care provided by VA. In FY 1992, 20 percent of the inpatients treated were treated in psychiatric bed sections.

In brief, we believe that research funding in the mental health area compares very favorably to that provided in the other areas. The Research and Development Program spends considerably more than 12 percent on research relevant to mental health when closely related, such as basic science studies of neurotransmitters and neurochemical changes underlying schizophrenia, are included. The inclusion of such studies results in a 19 percent expenditure for mental health. To increase the number of proposals funded in the mental health area requires an increase in the number of scientifically meritorious proposals submitted. Given the small psychiatric-to-patient ratio (1 to 49 as compared to 1 to 22 in internal medicine), it is understandable that more research proposals are not submitted.

The Research and Development Program has made special efforts to supplement the investigator-initiated research programs. For example, three special research centers have been established to conduct basic and clinical research on schizophrenia. A similar center is supported for research on alcoholism.

Finally, in recognition of the clear need for more research-trained psychiatrists, the Research and Development Program, in collaboration with the Office of Academic Affairs, operates a training program to prepare psychiatrists for research. Although the number of participants is relatively small, we believe this program is a significant beginning in dealing with the shortage of psychiatric researchers in VA.

HONORABLE JOHN D. ROCKEFELLER IV

Question 2: The Committee is aware that VHA may be implementing Resource Planning and Management (RPM) this Fall. Please review the funding for mental health services under RPM and describe the relationship between the two.

Answer: FY 1994 marks the initiation of a new resource planning and management (RPM) system for the VA's medical care system. It is a workload and patient based management system that is intended to improve the management of our limited resources and better define our resource requirements in the future. It is prospective in terms of policy, workload and costs. It will take several years before VHA can fully implement the new system and use it as the principal basis for our budget requests to the Congress. FY 1994 is the transition year for implementing RPM and VHA recognizes that there is a great deal of work to be done to improve the information's systems, the staff training and the development of national program policies. The Department believes that the new system is needed to allow the VA to compete and be in a leadership role in the changing national health care environment. It is important to keep in mind that FY 1994 is only a beginning of a new process and VHA does not plan major shifts in program of facility funding. There are some concerns that RPM will be like the old system--RAM--that was suspended because the potential impact on quality and the open-ended expansion of workload it promoted led to financial crises at many VA Medical Centers. However, unlike RAM, RPM is not a formula driven system. Rather, it is a management system that uses information to establish workload and budget targets that are negotiated with each medical center within the context of Agency policy. The FY 1994 planning process is still under way and the mental health programs are being supported and treated fairly. Of the increases recommended for new workload under RPM, the mental health programs are targeted for an increase. In addition, there are two mental health related initiatives in the President's budget--one for PTSD and another for the Homeless Program. The funding of mental health services within the medical care appropriation beyond FY 1994 is a policy matter that will be addressed in consultation with OMB, VSOs and the Congress in the budget request process.

(Page 4)

HONORABLE JOHN D. ROCKEFELLER IV

Question 3: Please provide the Committee with the total amount of money spent by the Department of Veterans Affairs for service-connected disability benefits for mentally ill veterans. Please provide this information for FY 91, 92, 93 (est.), 94 (est.), and 95 (est.).

Answer: As published in the Secretary's Annual Report, approximately \$3.4 billion was paid in Fiscal Year 1991 and approximately \$3.5 billion was paid in Fiscal Year 1992 for service-connected psychiatric and neurologic diseases. In Fiscal Year 1993 approximately \$3.6 was paid for service-connected psychiatric and neurologic diseases. We do not yet have sufficient data to provide estimates for FY 1994 and FY 1995.

Question 4: Please provide the Committee with the total amount of money and number of research projects funded during FY 1992 and FY 1993. Further, please provide the total number of VA research projects and the total amount of money spent on mental illness research.

Answer: In FY 1992 there were about 1,350 research programs concerned with aspects of mental disorders ranging from basic science studies of neurotransmitters and neurochemical changes underlying schizophrenia, affective disorders and cognitive deficits, to comparative treatment studies in various forms of mental illness and dysfunction to outcome and cost impact studies. VA provided about \$47.6 million for this research and an additional \$54.6 million came from extra-VA sources, e.g., NIH. The number of programs and the amount of funding for FY 1993 are estimated to be very similar to the figures cited for FY 1992.

The total number of programs funded with the Medical and Prosthetic appropriation of \$227 million for FY 1992 was 2352. The appropriation for Medical and Prosthetic Research for FY 1993 is \$232 million. Because of the loss of current services funding and a change in program focus, there will be a reduction in programs funded which are currently estimated to be approximately 2100.



**PARALYZED VETERANS
OF AMERICA**

Chartered by the Congress
of the United States

August 20, 1993

The Honorable John D. (Jay) Rockefeller IV, Chairman
Senate Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
Washington, D.C. 20510-6375

Dear Mr. Chairman:

This is in response to your letter of August 5, 1993, concerning the hearing on VA Mental Health Programs. In accordance with your letter, I have provided a response to the additional questions submitted.

Sincerely,

Terry Grandison
Associate Legislative Director

Enclosure



**PARALYZED VETERANS
OF AMERICA**

Chartered by the Congress
of the United States

Responses To Questions
Submitted to Paralyzed Veterans of America
In Follow-up To The August 3, 1993 Hearing
Of The Senate Committee On Veterans' Affairs
Regarding VA Mental Health Programs

1. Question: A number of witnesses at the hearing noted that VA cares for a significant portion of the veteran population suffering from mental illness. A National Institutes of Health study found that 50 percent of the veterans requiring psychiatric care receive it through VA. In your view, does the private sector offer the same range and quality of psychiatric services as offered by VA?

Answer: The private sector may, in many instances, provide the same quality of mental health services as offered by VA. However, the quantity, range and availability of those services would in no way be sufficient to absorb VA mental health patient load. For instance, nearly one-third of the services in the United States provided to care for the chronically mentally ill are provided through the VA health care system. VA has also pioneered unique specialized mental health treatment programs such as readjustment counseling and continuing care for post-traumatic stress disorder which are completely unknown in the private sector. For these and many other reasons, VA mental health programs are a national resource that cannot be duplicated or subsumed by the private sector.

2. Question: Experts have told the Committee that the number of veterans needing mental health services will increase with their advancing age.

A. Can we expect the private sector to absorb the increase in veterans needing such care?

Answer: According to reports, even if the private sector were able to provide the level of care required by the veteran population, the mental health benefits contained in the Administration's forthcoming health care reform plan would not be adequate to assure access to a full continuum of mental health care for most Americans seeking services, let alone for increasing numbers of older veterans requiring routine and specialized care. Despite the fact that a large percentage of VA's patient population is receiving mental health care, without entitlement reform in the VA, most veterans are not eligible to seek and receive the full range of mental health services within the VA at the present time.

- B. How can we strengthen the programs VA operates to ensure these veterans receive the care they need?

Answer: Major improvement to VA mental health services can only be achieved by passage of eligibility reform legislation to provide full access to comprehensive services for all eligible (core group) veterans. Eligibility reform must be accompanied by the provision of sufficient resources to upgrade VA's mental health programs and service delivery infrastructure.

3. Question: How would you rate VA's efforts in mental health research?

Answer: VA's mental health research program remains a significant part of the Department's overall research effort. Mental health research projects, compared to research in other fields, enjoy a very positive success rate in the VA merit review process, indicating that the vast majority of those projects that are actually submitted and considered to be good science are funded.

4. Question: In regard to the MIRECCs proposal, should both the research proposals and the site selection process be subject to peer review?

Answer: Support for research should always be predicated on the peer review process to ensure that only the best science is funded. As stated in PVA's testimony, legislation authorizing the establishment of MIRECCs should be amended to require peer review in the site selection process for the same reason.

QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER TO
RICHARD T. GREER
IN FOLLOWUP TO THE AUGUST 3, 1993,
OVERSIGHT AND LEGISLATIVE HEARING ON
THE DEPARTMENT OF VETERANS AFFAIRS' MENTAL HEALTH PROGRAMS

1. Experts have told the Committee that a bias exists against psychiatric disorders, both inside and outside VA. Witnesses have suggested that the social stigma attached to mental illness may be responsible for the creation of insitutionalized biases, such as limitation of insurance coverage for psychiatric treatments by both federal and private sector payers. Are the psychiatric treatment regimens any less proven than similarly priced medical or surgical treatments?
2. Witness have reminded the Committee that more than half of all veterans receiving mental health services are treated by VA personnel. In addition, many have noted the increasing trend of severe mental illness among the elderly.
 - A. If the level of services remained the same, what portion of veterans seeking mental health services in the future will VA be able to treat?
 - B. How can VA increase its ability to effectively treat this growing patient population?
3. The Committee recognizes that VA psychiatrists are burdened with extraordinarily heavy workloads, which leave less time available to formulate research ideas, develop grant proposals, and conduct research. Is this a significant reason for the lack of mental health research in VA?
4. As was discussed at the hearing, the Committee believes a clear nexus must be shown between primary care and mental health care. Could you please cite an example?
5. While 40 percent of VA's clinical workload is in mental health, only 12 percent of VA research funds are spent on mental health research. What important or essential mental health research is not being done right now as a result of underfunding?
6. Besides conventional outpatient and inpatient treatment approaches, what else can VA do to provide a full continuum of care?



TO: Senate Veterans' Affairs Committee
 FROM: Richard T. Greer, witness at August 3 hearing *RTG*
 representing the National Alliance for the Mentally Ill
 RE: Responses to post-hearing questions.

1. The National Institute of Mental Health recently, at the invitation of a congressional committee, undertook comparative treatment costs of mental illness and other illnesses. I include a summary prepared by the National Mental Health Advisory Council, which shows clearly that mental illnesses can now be diagnosed and treated as precisely and effectively as are other disorders in medicine. Therapeutic options for treating specific mental disorders have become more numerous, more specific and more effective. The efficacy of mental health treatments for specific disorders has now been systemically tested in controlled clinical trials that compare very favorably with other areas of medicine.

2. A) It is clear that if the level of mental health services in the VA remained the same it will mean the continuation of a wrongheaded and narrow misallocation of treatment funds that discriminate against veterans who are mentally ill.

B) The VA can certainly better treat mentally ill veterans by reallocating resources to that purpose. As to "effectively" treating them, the VA will not achieve this until it too "deinstitutionalizes" by moving greater numbers of people out of inpatient settings into communities and then either builds community mental health care systems or connects veterans to existing community care systems. But to move them out without access to supportive care is to repeat the disaster of deinstitutionalization that we have witnessed the past 30 years, which, among other consequences, has contributed greatly to homelessness in America.

3. The reason for the lack of mental health research is that the VA has not allocated from its research budget a proportion that matches the proportion of veterans with mental illnesses. If research dollars are available there will be a surprising surge in applications for it, notwithstanding the workloads.

In the early 1980s, NIMH invested scandalously few research dollars in the most devastating of all mental illnesses--schizophrenia. It was said that few research ideas existed, that few were interested, perhaps because of the stigma of the illness. After the preparation of a well-developed five-year research plan and a congressionally blessed expanded flow of research dollars, research ideas and subsequent knowledge about schizophrenia blossomed into one thousand flowers. Today the revolution in neuroscience owes some of its surge to this initiative in schizophrenia research.

4. Discussion of the interface between primary care and mental health care must recognize that severe and persistent mental illnesses are biologically-based illnesses, that they are far more prevalent than the conventional view of the matter, and that they are highly treatable, especially depression. Further, mental illnesses are often co-morbid with other disorders such as alcoholism. The first medical encounter of most persons with mental illness seeking help is a general physician. Because medication is fundamental in the treatment of most severe mental disorders, primary care physicians must increasingly school themselves in state of the art pharmacology.

5. Research on post-traumatic-stress disorder needs to be greatly expanded. It is logical for the VA to lead the way.

NATIONAL ALLIANCE FOR THE MENTALLY ILL

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6. The VA must provide veterans with mental illness who can function in the community with proper treatment and supports that add up to an array of services in community settings. It is not necessary to reinvent the wheel. The dynamic experimentation, model programs, demonstrations and well-tested community programs like the continuous treatment team models (PACT) that have been developed during the eighties offer plenty of options for the VA to develop the needed care for its veteran consumers of services. We know for most persons with mental illness, life in the community is the optimum care and treatment fundamental to a life of quality and dignity. Veterans are entitled to no less. One must ask, Why is the VA moving so slowly given the high percentage of veterans with mental illnesses?



DEPARTMENT OF VETERANS AFFAIRS
Medical Center
Perry Point MD 21902

August 20, 1993

In Reply Refer To:

Honorable John D. Rockefeller IV
Chairman
Senate Veterans Affairs Committee
Washington, DC 20510-6375

Dear Senator Rockefeller:

Thank you for the opportunity to testify on behalf of the American Psychiatric Association during your August 3 Hearing on the VA's Mental Health Programs. I hope that you will find my answers to your subsequent questions useful.

Please let me know if I can be of further help in your consideration of these important issues. You can reach me at (410) 642-1013 and FAX: (410) 642-1165.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "J. Lipkin, M.D.", is written over the typed name.

JOHN O. LIPKIN, M. D.
Clinical Professor of Psychiatry
University of Maryland
Chief of Staff, Perry Point VAMC

RESPONSE TO THE SENATE VETERANS AFFAIRS COMMITTEE QUESTIONS

Question #1: Experts have told the Committee that a bias exists against psychiatric disorders, both inside and outside VA. Witnesses have suggested that the social stigma attached to mental illness may be responsible for the creation of institutionalized biases, such as limitation of insurance coverage for psychiatric treatments of both federal and private sector payers. Are the psychiatric treatment regimens any less proven than similarly priced medical or surgical treatments?

Answer:

When the question of the relative efficacy of psychiatric treatments is raised in the context of "similarly priced" medical and surgical treatments, it becomes essential to make reasonable comparisons. I often hear comparisons between bypass surgery and psychiatric care. Costs over time should not be compared directly to single expensive episodes of care. In addition, the losses to the economy are very different in terms of lost wages, social costs, and human suffering costs.

If we compare acute episode costs, many acute episodes of psychiatric care compare reasonably with acute medical illnesses. Comparing chronic illnesses becomes much more difficult since diabetes, rheumatoid arthritis, or Hodgkin's disease can all require multiple hospital stays, extensive outpatient visits, and expensive medications. There are no cures for diabetes or schizophrenia, although schizophrenic patients tend to be less ill and do better when they are older.

In Senate Report 102-397, the Committee on Appropriations asked the National Advisory Mental Health Council to review some issues of cost and efficacy in the treatment of mental illness. The Council reports current information indicating, for example, that the treatment of major depression with modern antidepressant medication can be successful more than 85% of the time. Nearly as many patients with schizophrenia obtain relief from the most disabling symptoms of the disorder such as hallucinations and delusions.

Many medical and psychiatric treatments which continue for years have been proven to be useful. Treatment of schizophrenia with Clozapine, treatment of high cholesterol levels with Lovastatin, and the use of AZT in HIV positive patients are costly and appear to be of some benefit to the patients. The cost-benefit relationship or value of these treatments compared to lower cost approaches remains the critical and obscure question. These questions must be

answered by outcome research conducted by clinicians in real life settings, implementation of additional health systems research and the initiation of Mental Illness Research Education and Clinical Centers .

Question #2: Witnesses have reminded the Committee that more than half of all veterans receiving mental health services are treated by VA personnel. In addition, many have noted the increasing trend of severe mental illness among the elderly.

Question A: If the level of services remained the same, what portion of veterans seeking mental health services in the future will VA be able to treat?

Answer:

A. Based on the important staffing limitations in the VA system, it appears likely that maintenance of current levels of service will be unlikely because of the need to improve quality to meet both VA standards and those of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) . Despite the slow decline in the total number of veterans, changes in the health care system will probably make the VA a more important provider of mental health and other long term care services. Increases in the number of aging patients with complex behavioral and medical problems will increase demand on the VA system since these patients use more services than younger patients. For these reasons, it appears probable that unless the VA re-orient's its thinking about mental illness, it will be able to treat a declining percentage of eligible veterans with mental illness or dementia.

Question B: How can VA increase its ability to effectively treat this growing patient population?

Answer:

B. The VA can increase its ability to treat this growing patient population by spending a more proportionate share of its resources for their care, i.e. the VA has already reduced its long term inpatient hospital population severely so that reprogramming mental health inpatient care dollars for outpatient care will not be an effective approach. The basic elements to increasing the VA's capacity include:

- a. Staffing sufficient to improve quality of care.
- b. Increased ability to provide acute and long term care in proximity to the patient's neighborhood.
- c. An emphasis on continuity of care for these patients involving some use of case management techniques

and more active use of a spectrum of rehabilitative strategies including supervised housing, community residences, shared programs with other public sector providers of mental health care, and better early intervention.

d. As staffing levels begin to be improved, there will need to be a massive effort to redefine the mission of VA mental health care so that hospitals (both acute and long term) will "recover" from many of the attitudes and strategies which have been in place in order to cope with the current marginal staff/patient ratios.

Question #3: The Committee recognizes that VA psychiatrists are burdened with extraordinarily heavy workloads, which leave less time available to formulate research ideas, develop grant proposals, and conduct research. Is this a significant reason for the lack of mental health research in VA?

Answer:

There are multiple reasons for the relative lack of mental health research in the VA. Excessive clinical workloads have both reduced the number of well crafted grant applications submitted and decreased the attractiveness of VA employment for psychiatrists with an active interest in both clinical and research activities. Young psychiatrists have correctly seen other jobs as more likely to permit them to participate in clinical care, education, and research in a balanced way. When potential clinician investigators take jobs elsewhere, the VA's pool of research talent becomes smaller or fails to grow.

VA's virtually absolute insistence on investigator initiated research made it possible to fund a low number of mental health grants. Targeted research found with PTSD and the Long Term Mental Health Evaluation Project have been relevant, productive, and academically respected, yet VA has generally been reluctant to support targeted mental health research, challenging its potential to produce benefits.

Question # 4: As was discussed at the hearing, the Committee believes a clear nexus must be shown between primary care and mental health care. Could you please cite an example?

Answer:

Generally, a primary care physician provides the basic medical assessment, diagnosis, and treatment for patients. When specialized consultation appears necessary, the primary care physician makes referrals and then coordinates

with the patient and the consultants what further diagnostic and treatment approaches will be utilized. This ability to provide coordination derives from the physician's comprehensive understanding of the patient's medical needs, life situation, and personal wishes. Many psychiatric patients assign this role to their psychiatrist. At Perry Point, this describes the role of psychiatric physicians.

In many VA settings, psychiatrists perform all of the functions of a family practitioner for their patients because the long term nature of psychiatric illness and the limited willingness of other physicians to deal with the psychiatric problems have made it most reasonable for psychiatrists to fulfill this primary care role.

Question #5: While 40 percent of VA's clinical workload is in mental health, only 12 percent of VA research funds are spent on mental health research. What important or essential mental health research is not being done right now as a result of underfunding?

Answer:

A number of VA mental health research proposals in basic science, psychopharmacology, psychotherapy outcome rehabilitation, substance abuse, PTSD and other clinical topics have been approved but not funded over the past decade. Some of these proposals were funded by other agencies (NIH), and some of them were probably important. A range of research experts have cited topics which can have a critical impact on mental health in the coming years. Topics range from the use of imaging techniques (magnetic resonance imaging, etc.) to defining the parts of the brain involved in specific diagnoses to the specific groups of cells, neurochemicals etc. involved in specific brain activity. Clinical research about which techniques work better than others may help to establish cost benefit relationships between treatment approaches. Carefully designed epidemiological research can illuminate relationships between genetic causes and other causes of mental illness. In other words, psychiatric research stands on the threshold of important and useful breakthroughs in many areas. Predictions about which will be most productive or beneficial for patient care have never been highly accurate. When enough research across a full spectrum of relevant areas occurs, we are always surprised by what new information develops, and we are often surprised by where it develops. Important advances in the treatment of mental illness will come from a wide spectrum of research conducted by competent investigators, but predicting which outcome research, basic science research, or health systems research will solve the problems of mental illness is not productive.

The VA has an unmatched opportunity to support and benefit from research.

Question #6: Besides conventional outpatient and inpatient treatment approaches, what else can VA do to provide a full continuum of care?

Answer:

VA can enhance its continuum of care through specific initiatives:

1. Include mental health care as a centerpiece of the mission and vision of the VA health care system, (shared equally or proportionately with medicine , surgery, and rehabilitation medicine), i.e. patient care must be first priority.

2. Make a genuine commitment to proportionate staffing of mental health services so that staffing levels at medical centers are more nearly equal and so that specific disciplines or specialties do not dominate.

3. Revise eligibility to permit better definition of what care will be needed by which patients. Make funding decisions that reflect both population needs and facility willingness to address them in a balanced way consistent with the mission of the VA.

4. From the clinical perspective many improvements can be made by developing a continuum of mental health services which utilizes a primary care approach. i.e. every patient should have a specific care provider who will be their main reference point for acute care and necessary after care and who will be a resource to them if they need long term care. This sort of approach will require some realignment of thinking at many medical centers and in many of the VA's fledgling networks.

5. Establish and facilitate the development of easier linkages with other mental health providers so that social agencies and outpatient programs which are located near a patient can be involved in providing part of their care.

6. Develop financial support mechanisms for some of the most chronically ill so that it will be possible to house and feed them adequately outside of hospitals, shelters and jails.

QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER TO
CHARLES O'BRIEN, M.D.
IN FOLLOWUP TO THE AUGUST 3, 1993,
OVERSIGHT AND LEGISLATIVE HEARING ON
THE DEPARTMENT OF VETERANS AFFAIRS' MENTAL HEALTH PROGRAMS

1. Experts have told the Committee that a bias exists against psychiatric disorders, both inside and outside VA. Witnesses have suggested that the social stigma attached to mental illness may be responsible for the creation of insitutionalized biases, such as limitation of insurance coverage for psychiatric treatments by both federal and private sector payers. Are the psychiatric treatment regimens any less proven than similarly priced medical or surgical treatments?

2. Witness have reminded the Committee that more than half of all veterans receiving mental health services are treated by VA personnel. In addition, many have noted the increasing trend of severe mental illness among the elderly.

A. If the level of services remained the same, what portion of veterans seeking mental health services in the future will VA be able to treat?

B. How can VA increase its ability to effectively treat this growing patient population?

3. The Committee recognizes that VA psychiatrists are burdened with extraordinarily heavy workloads, which leave less time available to formulate research ideas, develop grant proposals, and conduct research. Is this a significant reason for the lack of mental health research in VA?

4. As was discussed at the hearing, the Committee believes a clear nexus must be shown between primary care and mental health care. Could you please cite an example?

5. While 40 percent of VA's clinical workload is in mental health, only 12 percent of VA research funds are spent on mental health research. What important or essential mental health research is not being done right now as a result of underfunding?

6. Besides conventional outpatient and inpatient treatment approaches, what else can VA do to provide a full continuum of care?

Medical Center

University & Woodland Avenue
Philadelphia, PA 19104

Department of Veterans Affairs

September 13, 1993

In Reply Refer To: 642/116

John D. Rockefeller IV
Chairman
Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Rockefeller:

Thank you again for inviting me to participate in the hearing of the Committee on Veterans Affairs last month. I am responding to the written questions that I received recently and I hope that these responses are not too late to be useful to you.

My first response is to the question that you asked during the hearing about the necessity for continuation of the Vet Centers. The answer that I wanted to give during the hearing and for which there was no time was that we need data. We know that the Vet Centers were needed in the past because there were many veterans who felt alienated from governmental programs. They would not have received help without the availability of the storefront Vet Centers located away from established Federal offices. In Philadelphia I am not sure whether this necessity still obtains. Many veterans come directly to the VA now and there seems to be much more acceptance of the friendliness of the VA Medical Center. My recommendation is to do a study that counts the numbers of patients who come into the system through the Vet Centers and determine the number who have not been seen previously at VAMCs. We could also interview veterans coming through the Vet Centers about whether they would be willing to come directly to VAMCs.

My responses to your written questions are as follows:

1. *Comparison of effectiveness of psychiatric treatments with medical or surgical treatments.* There have been numerous studies showing the effectiveness of psychiatric treatments. These have been conducted using scientific design including control groups and random assignment. They have been published in good medical journals subject to peer review. I have reviewed the outcome literature for medical and surgical treatments and I find that the psychiatric treatments are at least as well demonstrated by these outcome studies as are the medical and surgical treatments. Moreover, we can show that psychiatric treatment often reduces the need for subsequent medical treatment.

2. *A. Regarding the proportion of veterans seeking mental health services that we were able to treat.* I can only answer for the Philadelphia VA Medical Center. We are committed to treat all of the service-connected veterans who apply for treatment and all of the non-service connected veterans who have emergency problems. We are already forced to spend much of

our time trying to find other medical centers to whom we can refer veterans when all of our beds are full. Since we have too few psychiatric beds, we are frequently full. Our resources are stretched to the limit. We continue to treat everyone who comes to our door, but the level of services that we can give is diminishing. Without additional resources, the level of care will decline further in the future, but it is not possible to predict how far it might decline.

2.B. How can the VA increase its ability to treat this population. The VA can increase its ability to treat this growing population effectively only by increasing the proportion of resources that it allocates to mental health. This involves not only staff positions for physicians and nurses but also training slots for residents.

3. Reasons for lack of mental health research. The Committee is absolutely correct. The heavy clinical workloads are a major reason for the lack of mental health research in the VA. This heavy clinical workload increases the difficulty in recruiting research oriented psychiatrists who work in the VA and it wastes the potential for research that can be conducted within the VA population.

4. Primary care and mental health care. There definitely is a connection between primary care and mental health care. Again, the Philadelphia VA Medical Center is a prime example. We have about 3,800 veterans receiving outpatient care at our mental health clinic and substance abuse treatment unit. Our Medical Center has very minimal resources for primary care *per se*. However, for most of these 3,800 patients, the psychiatrist is their primary care physician. With the help of nurse practitioners, our psychiatrists provide regular physical examinations, regular blood tests and monitoring of nutritional status, blood pressure status, diabetes, epilepsy and other chronic disorders. We have health maintenance programs for early detection of tuberculosis, diabetes, hypertension, sickle cell and other diseases. We make referrals to specialty clinics as needed, but for the vast majority of patients, the psychiatrists continue to function as the primary care physicians.

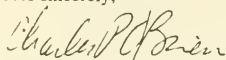
5. Mental health research underfunding. The important or essential mental health research that is not being conducted because of underfunding is difficult to specify. This is the "Decade of the Brain" and the basic science of psychiatry, that is neuroscience, is virtually exploding with new ideas and exciting discoveries. The VA is participating to a relatively small amount in this world of discovery. With even a modest increase of funding, there could be exciting new clinical research studies comparing new medications with standard medications for the treatment of depression and schizophrenia. With some investment in modern brain imaging equipment for mental health research, the VA could pursue studies of the physiology of mental illness including addictive disorders. At our hospital the diagnoses of psychosis and substance abuse are the most common. With such a great availability of potential research subjects with these disorders, the VA could make an enormous contribution to our understanding of the biology of these disorders if there were adequate funding. In the realm of psychosocial interventions, the VA could contribute important studies that determine which patient factors should be matched with which specific psychotherapy techniques. The possibilities of new research with adequate funding are endless and I could go on and on citing specific examples.

6. Non-conventional approaches. Besides conventional outpatient/inpatient treatment, the VA can provide more flexible treatment approaches. These approaches can be more cost effective than current standard treatments. For example, there have already been important studies conducted in the VA of day hospital care. This involves intensive outpatient care for patients with alcoholism or cocaine dependence. These treatments have been shown to be as effective as more costly inpatient care. The VA could also experiment with psychiatric treatment in transitional living arrangements. VA domiciliaries could be strategically located in cities perhaps in low cost housing near VAMCs. Nearby VA staff could be used to help in the rehabilitation of veterans with mental illness. Veterans could return to work while they

are receiving regular treatment and supervised living in the transitional living arrangement provided by these non-conventional doms.

These are my brief responses to your questions. I will be happy to provide more information including literature citations if these are requested.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "Charles P. O'Brien".

CHARLES P. O'BRIEN, M.D., Ph.D.
Chief, Psychiatry Service

QUESTIONS POSED BY SENATOR ROCKEFELLER TO
PATRICIA B. SUTKER, Ph.D. AND RESPONSES
SUBMITTED IN FOLLOWUP TO THE AUGUST 3, 1993
OVERSIGHT AND LEGISLATIVE HEARING ON
THE DEPARTMENT OF VETERANS AFFAIRS MENTAL HEALTH PROGRAMS

Question 1. Experts have told the Committee that a bias exists against psychiatric disorders, both inside and outside VA. Witnesses have suggested that the social stigma attached to mental illness may be responsible for the creation of institutionalized biases, such as limitation of insurance coverage for psychiatric treatments by both federal and private sector payers. Are the psychiatric treatment regimens any less proven than similarly priced medical or surgical treatments?

Response. If there are objective data by which to address this question, such information is not known to this respondent. There are few, if any, research investigations that allow comparisons of treatment effectiveness and outcomes across disease categories and service provider disciplines. A response then to this question falls into the category of opinion derived from experience within a specific area of clinical practice or discipline. Clearly, such opinions are biased in favor of the specific discipline; however, it is probably not controversial to argue that psychiatric treatment regimens and treatment initiatives provided by psychologists, who render both individual and group psychotherapies as well as highly specialized treatment and psychoeducational services to diverse categories of veterans, are as effective in terms of outcome as those rendered by medical and surgical practitioners.

Question 2. Witnesses have reminded the Committee that more than half of all veterans receiving mental health services are treated by VA personnel. In addition, many have noted the increasing trend of severe mental illness among the elderly.

A. If the level of services remained the same, what portion of veterans seeking mental health services in the future will VA be able to treat?

Response. Mental health care professionals, including both psychiatrists and psychologists, are faced with clinical service demands that stretch resources beyond the limits of effectiveness and compassion. Inner city medical centers, such as the New Orleans Medical Center, constitute the mental health service provider site for large numbers of veteran patients who have no other viable alternatives. For example, the numbers of veterans seeking services for war-related stress disorders, and post-traumatic stress disorder specifically, are sufficiently great as to tax existing resources at the New Orleans Medical Center. Both the sheer numbers of veterans presenting for services and the complex nature of mental disorders, particularly PTSD but also substance abuse disorders and other mental disorders, demanding time intensive professional attention, are factors that limit the scope of services provided. That is, professionals only have so much time even within extended working days to render services, and it is often the case that veterans

require more attention, or appear in greater numbers at a given point in time, than Medical Centers are equipped to accommodate. Therefore, if the level of services remained the same, any substantial increase in the numbers of veterans requiring or demanding services would severely overstretch the personnel resources of the New Orleans Medical Center in the area of psychological and psychiatric interventions. Moreover, the limited space allocated for such services is a restricting factor.

B. How can VA increase its ability to effectively treat this growing patient population?

Response. There are two general categories of change that can be effected within the VA system to address the increasing and progressively more complex patient care needs of veterans. The first and most obvious solution is for additional resources to be allocated for personal services expenditures (FTEE) and expanding facility space devoted to patient care services. As veterans become older and are troubled by a greater variety and combination of medical and psychological problems and as more women enter the system for assessment and treatment, it is clear that additional resources will be required in terms of mental health personnel and space for mental health activities, if veteran needs are to be addressed with quality, compassion, and confidentiality. Probably as important as the former, is the second category of change which could be implemented to the advantage of veteran patient care, or that of better and more effective utilization of existing resources. Suggestions in the latter category are outlined as follows: 1) There is a need to reexamine and restructure positive and negative incentive systems for VA employees such that middle- and upper-level management officials have greater flexibility and more options for both negative and positive reward actions to encourage productivity; 2) Special categories of professionals have been overlooked by the Congress in attempts to provide greater monetary incentives for mental health providers, e.g., psychologists. Recent changes in compensation structures for physicians and nurses are beneficial for these professionals, but psychologists perform unique and vital mental health services to veterans suffering from mental disorders as well as emotional and psychological distress associated with diseases. In efforts to bolster rewards for psychiatrists and to render the worksite more appealing, it is important that psychologists and their independent professional contributions be compensated at rates comparable to the private community; and 3) Mental health and other professionals are increasingly burdened with paperwork documenting, describing, and justifying assessments and treatments. Although such work is obviously vital to our complex health care system, this increased workload has taken its toll on professional time available for direct patient care activities.

Question 3. The Committee recognizes that VA psychiatrists are burdened with extraordinarily heavy workloads, which leaves less time available to formulate research ideas, develop grant proposals, and conduct research. Is this a significant reason for the lack of mental health research in VA?

Response. This is a difficult question to address because the query assumes that there is a lack of mental health research in the VA, and this is not the case. Though less mental health research is conducted within the VA than desirable, there is certainly a substantial body of research work conducted, as well as valuable findings emerging from mental health investigation in the VA. Second, the question assumes that psychiatrists are the primary group of professionals performing mental health research in the VA, or that psychologists as health care providers are not important to consider in providing for funding and other support for mental health research. Much of the mental health research conducted with VA funding is under the direction of and performed by psychologists, who may work independently of psychiatrists or in association with physicians of other disciplines. Psychologists constitute the principal investigators in as much as half of the mental health research. Therefore, the role of psychologists as overburdened health care providers, along with psychiatrists, must be considered in the process of attempting to render the VA a better worksite for mental health professionals. In summary, both psychiatrists and psychologists would benefit from relief in terms of greater clinical support to meet patient care needs, and the roles of both disciplines would be enhanced by the greater availability of competitive research funds. Finally, VA Medical Research funding is best conceptualized as available to all VA mental health care professionals, including both psychologists and psychiatrists, with equal access to these potential benefits depending upon the merit of the research proposals submitted.

Question 4. As was discussed at the hearing, the Committee believes a clear nexus must be shown between primary care and mental health care. Could you please cite an example?

Response. There is increasing need for clear and working linkages between mental health care providers, including psychologists and psychiatrists, and physicians who provide primary health care for the diverse health problems that appear initially in entry portals and throughout the course of a patient's life. Collaborative primary care models, encompassing integration with family physicians and internists positioned at entry portals in health care systems and specialized health care services provided by psychiatrists and psychologists in other components of health care systems, are vital to comprehensive and effective health care in our highly specialized medical and psychological arena. Mental health professionals can participate with Emergency Room and Ambulatory Care physicians to address mental health components of presenting problems, and mental health professionals can serve to organize and arrange for total care for individual veteran patients over time.

Question 5. While 40 percent of VA's clinical workload is in mental health, only 12 percent of VA research funds are spent on mental health research. What important or essential mental health research is not being done right now as a result of underfunding?

Response. Historically, research in the arena of mental health has been underfunded, underemphasized, and devalued. Although the entire gamut of mental health research issues might be reviewed, it is noteworthy that studies have been lacking in the epidemiology of mental disorders among veteran cohorts, particularly among veterans of World War II and the Korean Conflict. In recent years, greater attention has been devoted to the psychosocial problems of Vietnam Era veterans, but there has been little VA research work directed toward returnees of the Persian Gulf War, as well as the older veterans. The special problems of women veterans have also been infrequently the subject of research investigations. Areas where work is needed are the psychosocial aspects and behavioral approaches to AIDS, expression and treatment outcomes of post-traumatic stress disorder, treatment approaches to stress disorders more generally, natural expression of mental disorders over time and in response to specific types of interventions, and psychosocial and behavioral aspects relevant to management of emotional distress in AIDS patients and in prevention of transmission of the HIV virus. More research in neuropsychology and the interface of physical and mental disorders is also needed.

Question 6. Besides conventional outpatient and inpatient treatment approaches, what else can VA do to provide a full continuum of care?

Response. In this era of fiscal constraints, it becomes necessary for the VA to become a cooperative partner with community mental health care agencies and facilities such that assessment and treatment activities can be coordinated and shared in sites that are most convenient to veteran patients. Sharing agreements need to be explored with community mental health centers that are dwindling in client loads, and with psychiatric hospitals suffering loss of inpatient clients. Sharing agreements could provide an answer to problems with both space and FTEE within the VA and could provide assistance to beleaguered health care systems that have not adjusted to contemporary health care trends. Expansion and extensions of halfway house programming would also be of benefit throughout the country, including innovative day programs for veterans suffering from chronic mental illness and requiring day-to-day supervision. Supervised group homes and sheltered workshops for schizophrenics, homeless, and other chronically mentally ill veterans represent prominent areas for expansion within the VA continuum of care.



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August 13, 1993

Honorable John D. Rockefeller IV
Chairman, Senate Committee on
Veterans Affairs
Washington, DC 20510-6375

Dear Chairman Rockefeller:

The American Legion is pleased to respond to the follow-up questions received in relation to the August 3, 1993, hearing on VA mental health issues.

1. A number of witnesses at the hearing noted that VA cares for a significant portion of the veteran population suffering from mental illness. A National Institutes of Health study found that 50 percent of the veterans requiring psychiatric care receive it through VA. In your view, does the private sector offer the same range and quality of psychiatric services as offered by VA?

Reply

In VA, if a veteran is eligible and receives psychiatric care and treatment, the patient is provided care for as long as a need exists. VA offers as wide a range of outpatient services as found in the private sector. However, these services are not consistently applied throughout the system. Within the services available, VA makes every effort to provide cost-effective, high quality treatment. VA is not bound to abide by certain health insurance limitations on the quantity of care provided to veterans.

In the private sector, often the reverse is true. Private health plans often discourage providing proper care and treatment to patients through certain limitations imposed on the quantity of care the patient can receive. For example, a patient may be entitled to only a specific number of psychiatric counseling sessions per year, thereby restricting the amount of care provided. Health Maintenance Organizations (HMOs) have been described by some experts as most likely to limit mental health benefits. For this reason, health care experts complain that certain private sector patients do not receive adequate mental health treatment.

It is unfortunate that certain HMO plans limit access to outpatient mental health treatment. By discouraging the provision of adequate short-term coverage, patients may require costlier long-term hospitalization.

In our view, employers must negotiate more reasonable and effective mental health benefits when determining the scope of benefits offered by an HMO.

As to the issue of the quality of patient care, we have no precise information on this matter. However, in our opinion, the quality of patient care is likely affected when there are limits placed on the type and amount of mental health services available.

2. Experts have told the Committee that the number of veterans needing mental health services will increase with their advancing age.

A. Can we expect the private sector to absorb the increase in veterans needing such care?

Reply

The testimony provided before the Senate Committee on Veterans Affairs on August 3, 1993, suggested that state psychiatric hospitals do not have adequate resources to properly treat patients and that many of these patients may end up on VA's door step. VA needs additional resources to treat long-term psychiatric patients and to properly develop more treatment programs for the chronic and aging psychiatric patient. VA has developed a balanced infrastructure of programs in which to provide psychiatric care and treatment, however, they are not evenly applied throughout the system. More alternative outpatient treatment options are required, also. To our knowledge, there is no evidence to suggest that the private sector can absorb the current number of aging veterans requiring psychiatric care. For that matter, we seriously question whether VA will be able to adequately treat the expected workload increase.

B. How can we strengthen the programs VA operates to ensure these veterans receive the care they need?

Reply

Today, VA health care dollars devoted to psychiatric care totals approximately \$1.4 billion. Greater access to and expansion of outpatient treatment programs is necessary, along with additional resources to bolster current program staffing.

3. How would you rate VA's efforts in mental health research?

Reply

The American Legion endorses a strong research program for all veterans' related illnesses and diseases.

An estimated 26 percent of VA patients suffer from substance abuse problems and another 14 percent are afflicted with other forms of mental illness. We believe VA must balance its research efforts across the spectrum of patient care programs. We endorse the comments and recommendations made in the August 3 testimony of the American Psychiatric Association and the National Alliance for the Mentally Ill with regard to the need for greater psychiatric research in VA. Also, we strongly support the legislation to create and fund Mental Illness Research, Education and Clinical Centers (MIRECCs) within VA.

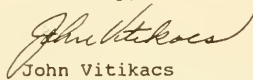
4. In regard to the MIRECCs proposal, should both the research proposals and the site selection process be subject to peer review?

Reply

The process should be similar to how the highly successful GRECC program is administered. Our belief is that the proposed MIRECCs should be clinically based and focus on the disease process and effective treatment outcomes. The MIRECCs could possibly link both highly affiliated medical centers and other non-affiliated facilities under one program to study as wide a range of mental illnesses as possible.

Thank you for providing us an opportunity to respond to these additional questions.

Sincerely,



John Vitikacs
Assistant Director for
Resource Development
National Veterans Affairs
and Rehabilitation Commission

QUESTIONS SUBMITTED BY SENATOR AKAKA TO
SUSAN ANGELL, Ph.D., M.S.W.
IN FOLLOW-UP TO THE AUGUST 3, 1993
OVERSIGHT AND LEGISLATIVE HEARING ON
THE DEPARTMENT OF VETERANS AFFAIRS' MEDICAL HEALTH PROGRAMS

1. Critics imply that Vet Centers never actually cure anybody and merely create a dependence on the part of veterans to justify Vet Centers' existence. Please comment.

The trauma of war and sexual assault does not have a time limited impact upon an individual's life. An individual who has survived the trauma of war and sexual assault is forever altered emotionally and biologically, creating disruptions in normal life cycle. When the affects of trauma go untreated they can become severe and chronic. Therefore, treatment generally entails comprehensive efforts to include individual therapy, group therapy, family therapy, job assistance, medical referrals, substance abuse counseling and finally reintegration into the community. Depending upon the resources each veteran comes to a Vet Center with, will help determine how long and how much intervention he or she will require. Many of our veterans arrive in a state of homelessness or with significant substance abuse problems, or in crisis with job loss or family disintegration or any combination of all of the above. In essence, this requires intensive work with numerous levels of intervention by Vet Center staff who will set up the necessary community resources to help each veteran. This process can take several years to complete, depending upon the severity of the veterans problems.

2. Is there any clinical evidence or research to show that Vet Centers actually help veterans get better? How do you actually measure whether you have helped veterans?

Presently, the Readjustment Counseling Service is instituting a Consumer Satisfaction Survey. This survey is to help determine the effectiveness of services. It is a self report survey that veterans will fill out. This survey will compare the veteran's first contact with the Vet Center and how their life situation was at that time, compared to their current situation. They will be asked to fill out the survey at different points in treatment and their involvement with Vet Center. We expect that the data provided by the veterans from this survey will be helpful in showing us the usefulness of RCS and the Vet Centers. However, the high popularity of the program within the veteran community and the significant support from veterans service organizations over all the years of the Vet Center existence, is clear testimony to the usefulness of RCS to combat veterans. Additionally, there have been very few complaints about services over the last fourteen years and at the same time, there have been many positive comments and good public relations and media attention given to RCS. Many veterans have been on television and in the print media to talk about how at times the Vet Center was the only service or organization that kept them alive during very difficult times in their life. I think this self report by veterans is as good a measure as one can get regarding the effectiveness and importance of a program.

3. Are you aware of current or past efforts to undermine the autonomy of the Vet Center program? If so, what was the reaction of yourselves and of your fellow Vet Center employees to these initiatives?

I am aware of previous attempts to change the location and/or organization of the Vet Centers which would have significantly impacted the program's autonomy of operation. The reaction of most employees is one of anger about having to fight for survival again, frustration at the amount of time wasted protecting the program from these attacks and great concern for the protection of resources for our veteran clients. As a manager, time must be spent clarifying roles and mission repeatedly at every level of the VA, because these become foggy during these periods of attack. Staff become concerned about stability of careers in RCS, particularly our non-traditionally degreed combat veteran staff, who are generally not hired in clinical positions and would have little chance for lateral transfers into the larger more formal system. As a manager, there is great concern for loss of the flexibility that has made this program so successful in terms of outreach activities and in terms of providing culturally diverse and appropriate treatment. There is also concern regarding how poorly this veteran population was treated by VA in the past and how unacceptable care by VA was to many veterans. Our combat population was a group that was not desirable for many clinicians in the VA, much the same way women veterans who sought care for sexual trauma have had numerous barriers to care in the larger, formalized system.

4. Are the duties and responsibilities of Vet Center Team Leaders commensurate with their pay grades? If not, could you give me an example how the pay grade rating between RCS and other services may be inequitable?

No, Vet Center Team Leaders are generally at the GS-11/12 level, unless they are psychologists, which are at the GS-13 level. They function independently, generally geographically far away from first line supervision. They must establish budgets, supervise VA staff, interns and auxiliary staff. They have large geographic areas of coverage. They frequently must manage media and public affairs issues independently.

5. Do Vet Centers have the expertise to provide bereavement counseling?

Vet Center staff do have the expertise to provide bereavement counseling should that part of the bill pass. Much of the work with war trauma has to do with loss and therefore, whether it is bereavement over a fellow soldier or in some psychological terms, a loss of innocence and values. In most combat groups there is a significant amount of bereavement counseling that goes on regarding losses suffered as a result of war. This loss may also include, loss of a limb and body function to some degree. Therefore, I think the skills that our counselors have currently can very easily be translated to bereavement counseling for family members who lose their relative in combat.

6. If the bereavement provision of S. 1226 is passed, would you expect that there would be many people who would present themselves for care? Would you expect to be able to absorb this number into the present workload?

I would not anticipate that there would be any need for extra resources to provide bereavement counseling to family members who have lost a relative as a result of combat. However, I do not know that there is any hard data to help to predict and determine how many people may come into the Vet Center for such counseling should it become available. It would be expected that if the United States continues to have hostile actions or be a participant in war activities, the number of eligible veterans could grow significantly. If we make this eligibility for bereavement counseling for any conflict we may see a need for more resources, particularly if the United States gets into a war resulting in massive casualties.

7. How, if at all, has VVRC status affected your ability to conduct outreach?

The concept of VVRC's in large metropolitan areas can be very useful. Outreach and services are enhanced by the increased number of people available to do outreach. More staff also can mean more varying areas of expertise that each person bring to the work site. This allows for increased breadth and depth of services provided. In essence VVRC's can increase the ability to do outreach and provide a larger range of services. VVRC's also increase the ability for a team to support outstations, which can increase access to care in densely populated areas.

8. Do you have veteran clients who currently use VA hospital services but who could benefit from follow-up care at Vet Center, thus relieving them of travel burdens and other hassles?

There are many veterans who come to the Vet Center who also use VA Medical Center services, particularly for outer island and rural Vet Centers. If they could receive some of their medical follow-up at the Vet Center, it would certainly relieve a lot of their time and discomfort in travel back to the medical center for follow-up care.

9. Is it administratively feasible to offer health care services in existing Vet Centers? Would physical modifications have to be made to accommodate health care personnel?

It is administratively feasible to consider offering health care, particularly primary health care service at existing Vet Centers. There may need to be some modifications depending on the requirements of the primary care giver, for instance, there may need to be a sink installed in some offices and as new leases are negotiated for Vet Centers, more space would certainly be a consideration, if primary care service were to be offered in the Vet Centers. Administratively, what would be critical is that the services would be offered on either a rotating or a part-time basis, with the understanding that the Team Leader of the Vet Center would have a large part of defining the medical need and facilities available to provide such primary care. It would be very important to staff who rotate through, to rotate through on a time limited basis, rather than to be permanently stationed in a Vet Center on a full-time basis, because then that creates difficulties with lines of authority. Therefore, it has worked best in the past to have nurses and physicians come to a Vet Center on a rotating basis were those issues do not come up as much as they would, if someone were permanently stationed full-time in a Vet Center.

10. Would introducing medical personnel into Vet Centers lead to loss of autonomy for the Vet Centers? If so, do you think that section two of S. 1226 which codifies the structure of the Vet Center program is enough of a safeguard to offset this danger?

I think if medical center personnel were introduced into the Vet Centers, and if line authority was respected and upheld and the medical personnel were part-time as I suggested in question #9, then there would not be a loss of autonomy for the Vet Centers. I think we could look at enhancing services to veterans by having some medical personnel in the Vet Centers on a limited basis. However, if there was a plan to place a number of medical personnel in a Vet Center, it may be wiser to consider co-location as a possibility where the medical center staff could have their own space that is not necessarily shared with the Vet Center, but would be located adjacent to the Vet Center. This would result in clear lines of authority and mission for both the Medical Center and Vet Center staffs.

2.

veterans service organizations and military units within a large geographic area. Many Team Leaders also function as technical representatives (COTR) for the RCS contract program. As COTR's they have responsibility for an additional budget and provide site visits to private sector therapists. Team Leaders also develop and supervise the duties of auxiliary staff such as work studies, DVOPs and volunteers. The Vet Centers offer a variety of services such as PTSD/readjustment counseling, disaster response, homelessness assistance, and sexual trauma counseling. Team Leaders have overall responsibility for all these programs. Hospital based supervisory personnel (comparable grade level) might be tasked with a portion of these tasks, but only a service chief would have the equivalent overall responsibility required of RCS Vet Center Team Leaders. Team Leaders, in addition to the above mentioned administrative duties, are required to provide direct clinical services 30% of their duty time.

5. Vet Centers not only have the expertise to provide bereavement counseling, but have been providing it to the veterans they serve as well as their families.

6. It is recommended that bereavement counseling provided by Vet Centers be limited to those veterans and their families who are affected by war-related losses. If this is the case, I feel the Vet Centers could absorb any additional workload that results.

7. VVRC status increases the staff available at a particular location. The additional staffing enables the VVRC to outreach veterans in the immediate community as well as provide outstations in surrounding communities thereby reaching veterans who might not ordinarily be reached. Moreover, more time can be devoted to the veterans who may be in need of assistance, but more resistant to seeking treatment on their own.

8. Veterans who are currently eligible for Vet Center treatment have follow-up services available to them upon discharge from a VA hospital. World War II and Korean veterans who are referred to a VA hospital by a Vet Center for treatment of their PTSD conditions currently are not considered eligible for follow-up care at Vet Centers.

9. I feel it would be administratively feasible to offer medical screening by physician's assistants and/or nurse clinical specialists at Vet Centers. Physical modifications and additional space would need to be evaluated on a case by case basis. More complex health care services would require more extensive corresponding physical modifications.

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10. Adding medical personnel to Vet Centers in and of itself would not lead to a loss of autonomy for Vet Centers since VAMC personnel currently provide services at Vet Centers or are actually co-located with some Vet Centers. However, an increased number of medical personnel being placed at Vet Centers could increase pressure in the direction of less autonomy. The provisions of S.1226 would appear to offset this potential danger.



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HONORABLE DANIEL K. AKAKA

Answer: Disaster assistance is very time limited and very occasional. It would be very rare for a particular Vet Center to be providing disaster assistance more than once per year, and frequently it is much less than that. The response to the new demand for services in the area of sexual abuse is made possible by the addition of 34 FTEE for new counselors. Also, it should be kept in mind that while the provision of counseling for sexual trauma sustained while on active duty is extremely important, the numbers of veterans needing services is small compared to the overall number of veterans provided with readjustment counseling including PTSD in combat veterans. Services for the homeless are limited from one to three per veteran, unless the veteran should appropriately receive PTSD counseling at the Vet Center over a more extended period. This occurs in approximately 10 percent of homeless cases. None of these specialized services detracts from the Vet Center's main emphasis on war-zone veterans, who continue to receive the bulk of visits.

Question 3A: How much additional caseload can RCS absorb without additional staff?

Answer: Essentially no additional caseload can be absorbed without additional resources. However, the answer to question 3C below addresses the specific issue of extending services to World War II and Korean War veterans.

Question 3B: How many additional staff would be needed to cover the additional caseload under S. 1226?

Answer: Section 4 of S. 1226 would make all veterans eligible for readjustment counseling at Vet Centers. Passage of this provision would approximately double the current workload, and result in the need to correspondingly double the current budget and FTEE (approximately 864 additional FTEE and \$57 million recurring addition to the annual RCS budget).

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HONORABLE DANIEL K. AKAKA

Question 3C: How many additional staff would be needed to cover the additional caseload created by entitling only WW II and Korean war veterans?

Answer: If only WW II and Korean war zone veterans (but not all veterans of those eras) were entitled to readjustment counseling, the additional caseload would be approximately 2500 veterans per year for ongoing counseling beyond initial intake and assessment. Our assessment is that this can be handled within existing resources. There probably would be some marginal reduction in number of visits by Vietnam Era (not Vietnam war zone) veterans seen for employment counseling or general social services, in that they would be referred somewhat sooner, in order to make a small amount of additional time available for combat veterans of WW II and the Korean war with long-standing PTSD.

Question 4: If VVRC's were expanded to all vet centers, what additional resources would be needed? Could the necessary FTEE simply be transferred from regional benefits offices?

Answer: Passage of Section 7 of S. 1226, requiring VA to expand and convert all Vet Centers to Veterans Resource Centers, would require an additional 2 FTEE at each Vet Center, plus additional costs for equipment, supplies, additional apace, etc. On a recurring annual basis this amounts to approximately 416 FTEE and \$20 million dollars in personal services and all other expenses. No additional FTEE can be transferred from the VA Regional Offices (VARO); since there have been major reductions in VARO FTEE in the field during the past decade, and no excess staff time is available from Veterans Benefits Administration.

VA service chief. For instance, team leaders generally are required to locate and negotiate for a suitable facility site. Furthermore, they are often responsible for negotiating and managing maintenance, cleaning, security, equipment and communications contracts. The VA service chief, on the other hand, relies on GSA or building management for these matters. Team leaders are also required to be experienced public speakers and responsible for a wide variety of public relations activities. Whereas, the VA service chief generally relies upon the station's local public affairs officer to handled these matters. Team leaders also have more strict budget criteria since the Vet Center is separate and autonomous from all other VA services. For example, while a VA service chief can "borrow" from another service to cover a fiscal "shortfall", the team leader cannot since the Vet Center's budget is restricted. Hence, the team leader's budget skills must be fairly exact to maintain a continuity of operation. Finally, team leaders generally insure that Vet Centers are open "after hours" to accomodate the veteran public. As a result, it is not uncommon for team leaders to work significantly extended hours without any additional monetary compensation.

Of course, team leaders are also responsible for all other clinical responsibilities of their Vet Center to include their own individual caseloads.

In summary, although team leader's often have many additional responsibilities in comparison to other VA service chiefs, their grade levels are lower and their opportunity for promotion is significantly poorer.

5. DO VET CENTERS HAVE THE EXPERTISE TO PROVIDE BEREAVEMENT COUNSELING?

Yes. Vet Centers almost specifically work with clients whoses issues and problems revolve around grief and loss. Furthermore, since its inception, Vet Centers have actively worked with family members of veterans. As practicing therapists, most Vet Center staff have had training in the area of death and dying. Nevertheless, specific bereavement training would be recommended to assure that all staff are up-to-date in their knowledge, abilities and skills.

6. IF THE BEREAVEMENT PROVISION OF S. 1226 IS PASSED, WOULD YOU EXPECT THAT THERE WOULD BE MANY PEOPLE WHO WOULD PRESENT THEMSELVES FOR CARE? WOULD YOU EXPECT TO BE ABLE TO ABSORB THIS NUMBER INTO THE PRESENT WORKLOAD?

At the present time, Vet Center's should be able to absorb this population into the present caseload since demand is not expected to be high. However, in case of war, particularly in areas of high military populations (i.e. near military bases), the demand would be expected to be significant enough to warrant an increase in staffing.

7. HOW, IF AT ALL, HAS VVRC STATUS AFFECTED YOUR ABILITY TO CONDUCT OUTREACH?

Since the Honolulu Vet Center is not a VVRC, no comment can be given.

8. DO YOU HAVE VETERAN CLIENTS WHO CURRENTLY USE VA HOSPITAL SERVICES BUT WHO COULD BENEFIT FROM FOLLOW-UP CARE AT VET CENTERS, THUS RELIEVING THEM OF TRAVEL BURDENS AND OTHER HASSLES?

Certainly, particularly in rural areas, follow-up care at Vet Centers would ensure continuity of care for many veterans for whom the VAMC is too far, or too difficult because of such issues as age or disability. Moreover, for numerous reasons, care delivered at Vet Centers would expectedly be less expensive than the same care delivered at a VAMC. Previous evaluations of cost effectiveness have consistently shown that care delivered at Vet Centers is significantly less expensive than the same care provided at a VAMC.

9. IS IT ADMINISTRATIVELY FEASIBLE TO OFFER HEALTH CARE SERVICES IN EXISTING VET CENTERS? WOULD PHYSICAL MODIFICATIONS HAVE TO BE MADE TO ACCOMMODATE HEALTH CARE PERSONNEL?

I can only address this question as it applies to the Honolulu Vet Center. The present facility would be insufficient since it currently has no additional space to expand services or personnel.

With an aging veteran population, expanded accessibility of services is a worthwhile endeavor. Such services should be limited to primary care and follow-up. Most importantly, extreme care must be exercised to ensure that the unique mission of providing readjustment counseling services is not lost to issues of medical care.

10. WOULD INTRODUCING MEDICAL PERSONNEL INTO VET CENTERS LEAD TO LOSS OF AUTONOMY FOR THE VET CENTERS? IF SO, DO YOU THINK THAT SECTION TWO OF S. 1226 WHICH CODIFIES THE STRUCTURE OF THE VET CENTER PROGRAM IS ENOUGH OF A SAFEGUARD TO OFFSET THIS DANGER?

This is a little like being asked to predict when the volcano will erupt! Of course some autonomy would be lost when missions and personnel with different philosophies and training backgrounds are mixed. It's like mixing two colors of paint, we know the colors will change but were not quite sure to what.

Although S. 1226 is a significant effort to safeguard against this danger, I don't believe it is sufficient in and of itself. Vet Centers are small and resource poor--in essence, a single team leader and office manager are busy enough with present administrative issues and will, without additional support personnel, have difficulties managing the needs, problems and issues brought by the presence of VAMC personnel on site. In essence, Vet Center's will at minimum need additional clerical support.

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improvement through the use of psychological measures, behavioral observations, and clinical self-reports. While we recognize the reality of not being able to help every veteran who presents for assistance, it is equally clear that we have been able to help significant numbers of our clients improve their lives through the use of individual and group counseling.

3. Over the past several years, two major attempts to undermine Vet Center autonomy occurred within the Department of Veterans Affairs. One involved a move to close certain Vet Centers and to relocate others into the Medical Centers. Only efforts by Congress to deny Department of Veterans Affairs freedom to comply with these plans preserved Vet Center autonomy and flexibility. Last year, the Department of Veterans Affairs again attempted to reduce Vet Center direct line authority by formulating plans to eliminate Readjustment Counseling Service regional offices, and to have Vet Centers placed directly under hospital Chiefs of Staff. Vet Center staff were highly suspicious of both plans, for much of the program success over its 13 year history has been attributed to the creative, flexible, and fast-paced ability of management to respond to changing conditions and to allow for Centers to adapt to local community cultures and to exert a strong degree of autonomy. Any shift to control by medical systems would invariably threaten the heart and soul of Readjustment Counseling Service, as many physicians traditionally have an unsympathetic view towards mental health services and operate in a strict medical model. This would be in specific conflict to Vet Center adherence to a psycho-social model of the development and treatment of combat-related trauma. Vet Center staff were opposed to threats to alter the program structure, which created morale problems until political process sidetracked these efforts.

4. The Team Leader in most Vet Centers functions as both administrative and clinical supervisor. As such, this person has duties similar to any Chief of a hospital service. Although supervising less staff members, the Team Leader has responsibility for outreach and community networking, media involvement, provision of community education and professional training, and participation in clinical research. These functions often surpass what may be expected of supervisors in medical settings. This really would suggest that Vet Center pay grades fall below the level of work and responsibility, especially for Team Leaders and Office Managers. In the case of Office Managers, the administrative workload and duties, direct client interaction, skills required for computer operation, and outreach responsibilities appear to greatly exceed the performance criteria of hospital or clinic administrative support personnel. However, pay grades for office managers often fall below those of staff working in medical facilities. Generally, it would appear that there is a difference of one grade level

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between comparable Department of Veterans Affairs personnel and staff working in Readjustment Counseling Service.

5. As Posttraumatic Stress Disorder may be considered to be an illness of "impacted grief", Vet Center counselors are frequently required to deal with issues of death and dying in both individual and group treatment. Additionally, the symptom of survivor guilt in combat veterans specifically involves issues of grief over buddies who have been killed in combat. Therefore, significant counseling work performed by Vet Center staff has incorporated the concept of bereavement. Nevertheless, if such counseling were provided to family members of troops killed in combat, the expanded eligibility for Vet Center services would require additional training for Center staff with respect to treating civilian family members. A potential increase in staff at those Centers showing greatly increased productivity, as a function of these additional services, might also result.

6. The number of persons specifically seeking counseling for bereavement would vary depending upon the effort expended to market and publicize the availability of these services by Department of Veteran Affairs and Readjustment Counseling Service. Additionally, significant increase in workload would occur under conditions when the United States military was engaged actively in military operations, to include combat. It would be anticipated that, the level of publicizing these services, the credibility of Vet Center staff in providing grief counseling, and the ability to educate perspective clients about the long term psychological effects of grief would significantly increase workload. An increase in FTEE should be considered in Centers providing extensive grief counseling, in addition to restricting eligibility for these services to civilians who have had service members killed in combat or in actual training operations.

7. While not working in a VVRC, it is my belief that any facility which has additional staff to handle the workload of direct clinical services, benefits and claims assistance, employment placement and counseling, and coordination of social needs, would have increased ability to provide expanded outreach to under served populations and to those individuals living in geographically remote areas.

8. Significant numbers of Vet Center clients are referred to Department of Veterans Affairs hospitals and clinics for numerous medical problems, medication consultation, and evaluation for hospitalization. Often these veterans have to travel great distances and face long delays in getting appointments to obtain these medical services. Clearly, the community-based locations of Vet Centers, combined with their personalized and informal environments, would provide an effective location for providing

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

HEARING ON VA MENTAL HEALTH PROGRAMS
AUGUST 3, 1993

SENATOR FRANK H. MURKOWSKI
RANKING MINORITY MEMBER

QUESTIONS CONCERNING S. 1226

Questions Submitted to the
Department of Veterans Affairs

Question 1: Under current law (either Sec. 510(b) or Section 1712A (g)), would VA be required to report to Congress before implementing a proposed reorganization or reduction in the scope of the Readjustment Counseling Service (RCS) or its Vet Centers?

Answer: The Congressional reporting requirements of 38 U.S.C. 510 (b) apply to an administrative reorganization, which involves loss of function and the requisite triggering FTEE cuts, at a covered field office or facility. Since a covered field office or facility is defined as one that has 25 or more employees or that is a free-standing outpatient clinic, and since all Vet Centers have fewer than 25 employees, reorganization at Vet Centers would not be subject to section 510 (b) reporting requirements. However, VA is required to inform Congress in advance of any closing or physical relocation of a Vet Center in accordance with the provisions of 38 U.S.C. 1712A (g)

Question 2: Does VA have any plans to reorganize RCS in such a way as to impair the ability of RCS to perform its mission?

Answer: No.

Question 3: Since RCS was established, has RCS ever been subjected to reorganizations which have had an adverse impact on its operations? If yes, when did the reorganization take place, what was the nature of the change and what were the adverse effects?

Answer: The organization of VA's program of readjustment counseling, furnished in Vet Centers, during the first 2-1/2 year period, from October 1979 to December 1981 was as follows: The Vet Centers were under the local VA medical facilities, specifically, the Chief, Psychology Service (and in a few instances, the Chief Psychiatry Service, or Chief, Social Work Service), for administration and supervision. There was not a Readjustment Counseling Service (RCS), and the program was administered in VA Central Office by the Mental Health Service.

The Vet Centers were opened during this period and became quite popular with the public, although they carried high caseloads. However, there was considerable adverse impact because of failure to implement the fee/contracts program of counseling, hiring of some employees who were not qualified and significant lack of collaboration between Vet Centers and medical facilities. Assurance of quality of services was quite spotty system-wide. Eventually, a total of over \$40 million earmarked for readjustment counseling was spent for other purposes. Because of this, the Chief Medical Director and the then Administrator of VA created the Readjustment Counseling Service in VACO, and authorized line authority over all operations and services through RCS regional management staff, fenced all funds and made a number of other operational changes. Since then, there have been recurrent proposals within VA -- the most recent in 1991 and 1993 -- to either disband the RCS line authority for supervising the Vet Centers, or abolish the Service altogether. The proposals were abandoned due to programmatic concerns and opposition from veterans' organizations and congressional sources.

Question 4: Under current law, are there VA services or organizational units (other than Readjustment Counseling Service) subject to restrictions on the Secretary's authority to organize or reorganize beyond the restrictions provided by Section 510 (b)?

Answer: We are not aware of any.

Question 5: Is Section 2 of the bill necessary to ensure the RCS remains able to perform its mission?

Answer: Not during this Administration.

Question 6: What other VHA organizations are designated as "services" comparable to Readjustment Counseling Service? Are the administrative and organizational structure of any of these services "frozen" by statute in their current form? What would be the effect of such a freeze? Should the existence of these services be mandated by statute? Why or why not?

Answer: Hospital Based Services, Ambulatory Care and Rehabilitation and Prosthetics are "services" comparable to the Readjustment Counseling Service. No services have administrative and organizational structures frozen by statute. The effect of a freeze would be to insulate the service involved from management directed changes inconsistent with the statute. We do not support mandating the existence of these other services because that would restrict managerial discretion with respect to the support, organization, supervision and operation of VA medical centers.

i. to Congressional committees and GAO, 5 U.S.C. 552a(b) (9), (10);

ii. to some one other than a VA employee in order to protect the health or safety of an individual, 5 U.S.C. 552a(b) (8);

iii. to civilian criminal law enforcement authorities who need the records for an authorized law enforcement purpose, 5 U.S.C. 552a(b) (7); and

iv. to VA officials and employees, such as the Secretary, the Inspector General or the General Counsel who currently may have access to perform their agency duties, 5 U.S.C. 552a(b) (1).

Question 12: Does VA have any plans to reduce or withdraw the protections of confidentiality now provided to Vet Center clients?

Answer: No.

Question 13: Would VA be able to conduct quality assurance, workload verification, or other management studies of Vet Centers if S. 1226 were enacted and RCS staff were prohibited from releasing information outside of the Readjustment Counseling Service?

Answer: Workload verification and other management studies are carried out by the Readjustment Counseling Service (RCS) managers. Studies of RCS by non RCS personnel (GAO and internal VA studies) have been carried out without any apparent need to see individually identified client records. We see no reason why this should change in the foreseeable future. However, at some point, in an unusual situation, oversight, audit and management of any VA program may require that VA personnel other than program personnel have the ability to examine all aspects of the program, including individual treatment or counseling records. Absent a court order, the proposed legislation limits access by VA personnel who do not work for RCS to the situation where disclosure is necessary to avert imminent danger to an individual, section 5(a) (3) of S. 1226, which precludes access by all other VA employees for any other reason. Consequently, without a court order, only RCS personnel could conduct RCS program oversight and management; this access limitation could severely limit VA's ability to adequately manage the RCS program.

Would VA's IG have access to Vet Center data?

Answer: Because S. 1226 specifically limits access to RCS records by agency personnel outside RCS to one situation, all other disclosures to VA personnel would be barred. As a result, VA IG personnel legally could not have access to Vet Center data unless IG obtained a court order granting access.

Question 14: In your opinion, what would be the effect on VA and RCS if the restrictions on release of data in S. 1226 were enacted?

Answer: While the proposed legislation is generally consistent with the current VA policy and practice of maintaining the confidentiality of Vet Center client records, enactment of section 5 of S. 1226 has the clear potential in the occasional circumstances to significantly restrict VA's ability to effectively and efficiently manage the RCS program. Under that provision, VA would need to obtain a court order whenever the Secretary, the IG, the General Counsel, or other agency personnel needed to see the records. Further, Congressional committee and GAO access to these records would be similarly affected. In another example, if VA felt it necessary to notify some one outside VA in order to protect the health and safety of an individual, a court order would be required, no matter how emergent the situation. Finally, VA would need to obtain court order to provide RCS records to a former employee if the records were needed in a personnel action against that RCS employee over his or her performance. These and other examples suggest that the proposed confidentiality provision is too restrictive, and that current law and practice already provide for the confidentiality required by RCS client records.

Question 15: If additional protection of privacy for RCS clients is necessary, can you provide it within your existing authority?

Answer: Based on the agency's experience since the creation of the Vet Center program, at this time the protection provided for the privacy of RCS clients is adequate; consequently, we currently do not see a need for additional protection of the privacy of RCS clients. If changes in circumstances so require we will seek appropriate additional confidentiality authority.

Question 16: In your opinion, are additional statutory restrictions on the release of data necessary?

Answer: No, not at this time.

- Question 26: Which of these advisory committees are required by statute to have two-thirds membership selected from their subject area clientele?
- Answer: None.
- Question 27: Does VA have any plans to disestablish, or reduce funding for, the existing Advisory Committee on the Readjustment of Vietnam and Other War Veterans?
- Answer: VA has no plans to disestablish, or reduce funding for, the existing Advisory Committee on the Readjustment of Vietnam and Other War Veterans.
- Question 28: Is a statutory mandate for a specific budget line item necessary to ensure that the Advisory Committee on the Readjustment of Vietnam and other War Veterans receives appropriate resources?
- Answer: No.
- Question 29: Should other advisory committees also have a mandated separate budget line?
- Answer: That is unnecessary.
- Question 30: Under current law, does VA have the authority to provide Vietnam Veteran Resource Centers (VVRC) service at additional vet centers?
- Answer: Yes, under existing law VA could enhance Vet Centers and make them resource centers.
- Question 31: What resources would be required to expand the scope of services provided at a Vet Center to the level of service provided at a VVRC?
- Answer: Approximately \$129, 542 per site, plus two FTE.
- Question 32: Does current law give VA the authority to use a Vet Center as a site to provide primary medical care to veterans?
- Answer: Yes, under current law VA could provide primary medical care to veterans at Vet Centers.

Question 33: Do you favor using Vet Centers as a site to provide primary care medical services?

Answer: We do not favor integrating primary medical care services into the current Vet Centers. The integrity of the Vet Centers needs to be maintained as primarily counseling centers. If new clinics are established, they could be near or adjacent to Vet Centers.

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